BENEFITHelp Solutions

City of Salem

CAFETERIA PLAN Health FSA,
DCAP and Premium Component

Summary Plan Description

Jan. 1, 2023

Table of Contents

Introduction

Welcome to City of Salem's cafeteria plan. This summary plan document is effective as of Jan. 1, 2023.

A cafeteria plan allows eligible employees to choose from a menu of different benefits to suit their needs and to pay for those benefits with pretax dollars.

This summary plan description (SPD) outlines the basic features of the plan, how it operates and how to get the maximum advantage from it. This summary does not describe every detail of the plan and is not meant to interpret or change the provisions of the plan. A copy of the Master Plan Documents (MPD) is on file in the City of Salem office for participant's use.

City of Salem includes the following in its cafeteria plan:

- Healthcare premium payment
- Health flexible spending arrangement (health FSA)
- Limited health flexible spending arrangement (limited health FSA)
- Dependent care assistance program (DCAP)

Legal status

This plan is intended to qualify as a cafeteria plan under IRS Code section 125 and the regulations issued thereunder, and shall be interpreted to accomplish that objective. The plan also includes a health FSA component defined under IRS Code section 105 and a DCAP component defined in IRS Code section 129.

Participation

Eligibility

An employee is eligible to participate in City of Salem's plan if the employee is is scheduled to work 20 or more hours each week.

Employees do not include the following:

1. Any common-law employee who is a leased employee
2. Any common-law employee who is classified by City of Salem as a contract worker, independent contractor, temporary employee or casual employee
3. An individual who performs services for City of Salem but is paid by a temporary or other employment or staffing agency
4. Any employee covered under a collective bargaining agreement
5. Self-employed individuals, partners in a partnership or more-than-2-percent shareholders in a Subchapter S Corporation

Enrollment

An eligible employee will be invited to join the plan on the first of the month following the date of hire. At that time, the eligible employee will be given an Election Form/Salary Reduction Agreement. The materials provided with the Election Form/Salary Reduction Agreement must be returned within 30-days of the effective date. If the forms are not completed within the allotted time, the eligible employee will not be eligible to participate for his or her initial plan year, unless an applicable change in status occurs (please see *Change in status*).

City of Salem will request that each eligible employee fill out an Election Form/Salary Reduction Agreement.

Termination of participation

A participant will no longer be eligible to participate if:

- The plan is terminated.
- The participant submits a false or fraudulent claim.
- The participant is no longer an eligible employee because of retirement, termination of employment, layoff, reduction in hours, etc.
- The participant fails to make his or her elected contribution.
- The plan year has ended — Dec. 31 for eligible employees.

Participation following termination of employment or loss of eligibility

If a participant ends his or her employment:

- But is rehired within 30 days, the eligible employee will immediately rejoin the cafeteria plan with the same elections he or she had before termination.
- But is rehired after more than 30 days following termination, the eligible employee may immediately rejoin the plan and make new benefit elections. Any unused reimbursement benefits account balance prior to the initial separation of service date will be forfeited.

If a participant becomes ineligible for any reason other than termination of employment, the eligible employee may immediately rejoin the plan.

Contributions in the event of termination will end the first day of the month following the date of termination unless the participant elects to continue his or her cafeteria plan benefits through COBRA.

Participation following termination, COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that gives certain employees, spouses and dependent children of employees the right to temporary continuation of healthcare coverage following termination of employment. For City of Salem employees, COBRA allows for continued coverage under the major medical or other health insurance plans at group rates. If an eligible employee, or the employee's spouse or dependent children, experience a qualifying event such individuals will be entitled to elect COBRA and to continue the same coverage at the time of the qualifying event, subject to payment of the applicable premium (which is, up to 102 percent of the combined amount paid by City of Salem and eligible employees). Qualifying events are those that would cause an individual to lose his or her health insurance coverage, if not for the COBRA rules. These events include the following:

- Termination from employment or a reduction of hours
- Divorce or legal separation from a spouse
- Becoming eligible for Medicare benefits
- When a child ceases to be considered a dependent

If the qualifying event is termination from employment, then the COBRA continuation coverage runs for a period of 18 months following the date that regular coverage ended. COBRA continuation coverage can be extended to 36 months if another qualifying event occurs during the initial 18-month period. It is the responsibility of the COBRA participant to inform the plan administrator of the second qualifying event within 60 days of the second qualifying event occurring. COBRA continuation coverage also can be extended to 29 months if an individual is disabled within 60 days after the date the entitlement to COBRA continuation coverage initially arose and if that individual continues to be disabled at the end of the 18 months.

Leave of absence

If a participant goes on qualifying leave under the Family Medical Leave Act (FMLA) or other applicable state leave law, then City of Salem will continue the participant's benefits as if he or she were an active eligible employee. Participants can maintain their contributions in one of the following way(s):

1. Under an arrangement agreed upon between the Participant and the City of Salem.

Unprotected leave of absence

If a participant goes on a leave of absence that is not protected under an applicable law, City of Salem will continue the participant's benefits as if he or she was an active eligible employee. Participants can maintain contributions in one of the following way(s):

1. Under an arrangement agreed upon between the Participant and the City of Salem.

Additional provisions apply for participants that extend their protected or unprotected leave beyond 12 weeks. Please contact City of Salem for details.

Elections

First elections

Once an employee has met the eligibility requirements (outlined under *Eligibility*) City of Salem will provide an Election Form/Salary Reduction Agreement. The eligible employee will be asked to decide whether he or she would like to participate in the health FSA, limited health FSA or DCAP and how much he or she would like to contribute. Contributions are made on a pretax basis and will be available for reimbursement during the period of coverage which begins on the first day of participation and ends on Dec. 31.

Funds remaining in the DCAP are irrevocable. Funds remaining in the health FSA will be used as described in Health Flexible Spending Account, regardless of whether an election is made for subsequent plan years.

City of Salem will request that each eligible employee fill out an Election Form/Salary Reduction Agreement.

Open enrollment

During open enrollment each year, participants will be asked to complete an Election Form/Salary Reduction Agreement. At that time, the participant is welcome to change any previous benefits and election amounts. Any such election changes made will be effective prospectively beginning on the first day of the new plan year. The plan year after the first plan year runs from Jan. 1 to Dec. 31.

Failure to elect

If an eligible employee fails to file an Election Form/Salary Reduction Agreement, the employee is considered to have elected not to participate for the plan year, ending on Dec. 31, unless a pertinent change in status is observed (please see *Change in status*).

Irrevocability of elections

A participant's elections under the plan are irrevocable during the plan year. Once participants have elected their salary reduction amounts and benefits, they cannot change their choices unless an applicable change of status occurs (please see *Change in status)*.

Change of status

A change of status allows a participant to make new elections with respect to the components affected by the change of status. Each change of status is described below:

- Legal marital status
  Including marriage, divorce, death of a spouse, legal separation or annulment
  Applies to: premium, health FSA and DCAP components
- Number of dependents
  Including birth, death, adoption or placement for adoption
  Applies to: premium, health FSA and DCAP components
- Employment status
  Including termination of employment, a strike or lockout, a commencement or return from an unpaid leave of absence, change in worksite, or eligibility conditions causing a change in eligibility (i.e., moving from salaried to hourly and becoming ineligible for benefits)
  Applies to: premium, health FSA and DCAP components
- Reduction of hours
  Including reduction of hours under 30 hours per week does not result in loss of eligibility for healthcare benefits
  Applies to: premium component
- Dependent eligibility requirements
  Dependent loses eligibility status by attaining a specified age or similar circumstance
  Applies to: premium, health FSA and DCAP components
- Change in residence
  Change in place of residence that causes the gain or loss of eligibility for the participant, spouse or dependent
  Applies to: premium, health FSA and DCAP components
- Loss of spouse or dependent eligibility; special COBRA rules
  Modification for the affected individual only
  Applies to: premium and health FSA components
- Gain of coverage eligibility under another employer's plan
  Applicable if a change in marital status or change in employment status provides eligibility for coverage under another employer's cafeteria plan
  Applies to: premium and health FSA components
- DCAP benefits
  Eligible employee ceases to have any eligible dependents
  Applies to: DCAP component
- HIPAA enrollment rights
  An eligible employee or his or her dependent becomes entitled to special enrollment rights under the Health Insurance Portability and Accountability Act (HIPAA) because the eligible employee loses coverage under another employer's group health plan; the eligible employee gains a dependent; the eligible employee becomes eligible for health plan premium assistance under Medicaid or a State Children's Health Plan (CHIP) program; or an eligible employee loses eligibility for Medicaid or CHIP coverage
  Applies to: premium component
- Judgment, decree or order
  An eligible employee is ordered to provide health coverage for his or her child under a judgment, decree or order resulting from a divorce, legal separation or change in legal custody
  Applies to: premium and health FSA components

- Change in Medicare/Medicaid eligibility
  An eligible employee, his or her spouse, or his or her dependent becomes enrolled or disenrolled in Medicare or Medicaid and the eligible employee would like to cancel or reinstate group health coverage for the Medicaid or Medicare eligible or recently ineligible individual
  Applies to: premium and health FSA components
- Change in cost
  Including a significant cost change for premium or dependent care benefits
  Applies to: premium and DCAP components
- Change in coverage
  Including significant curtailment of coverage, additional or significant improvement of salary reduction plan option, loss of other group health coverage, change in election under another employer plan, DCAP coverage changes
  Applies to: premium and DCAP components

Benefits

How it works

The premium component may require payment contributions, and the health FSA, limited health FSA and DCAP components will require contributions that can be used for permissible expenses. All of these contributions will be pulled from the employee's wages or salary prior to taxes.

The benefits elected during the initial enrollment or subsequent open enrollments cannot be changed without a permissible change in status (please see *Change in status*).

For example, Employer ABC offers its employees a cafeteria plan that includes premium payment, health FSA and DCAP options. Employee X becomes eligible and decides he would like to enroll in the cafeteria plan and utilize the premium payment and health FSA. Employer ABC has offered to assist with premiums and pays 80 percent of the total premium payment. Employee X is then responsible for 20 percent of his premiums and the elected amount for his health FSA. He chooses to elect $2,500 for the plan year. Employer ABC pays its employees every other week for a total of 26 pay periods in the year. Below is a table demonstrating what will be taken out of Employee X's paycheck prior to taxes and what will be taxed:

Benefit	Salary (pretax)	Premium	Health FSA	Salary (taxed)
Plan year	$40,000.00	$520.00	$2,500.00	$36,980.00
Pay period	$1538.46	$20.00	$96.15	$1422.31

Participation in the cafeteria plan does reduce participants' reportable wages. There could be a decrease in Social Security benefits and/or other benefits (e.g., pension, disability or life insurance). The tax savings provided in cafeteria plans usually more than offsets any reduction in other benefits. However, all benefits are available for contribution with after-tax dollars. Employees interested in participating in benefit plans with after-tax dollars should arrange this with City of Salem.

The cost of administering the cafeteria plan is paid entirely by City of Salem, except for amounts that are offset by end-of-year forfeitures.

Premium payment

During open enrollment. City of Salem will request that each eligible employee fill out an Election Form/Salary Reduction Agreement.

During the plan year. Participants will be eligible for all healthcare benefits provided under their elected insurance plan. Each contribution is an equal amount determined by the premium insurance benefit. The premium insurance benefits are subject to the terms and conditions of the respective insurance carrier's policy.

After termination. If a participant terminates his or her plan because of a COBRA-qualifying event (please see *Participation following termination, COBRA*), he or she may be eligible to continue his or her premium insurance benefits under COBRA laws.

If a participant chooses to elect COBRA benefits, he or she will be required to submit the appropriate premium payment by the first of each month or COBRA coverage will be terminated.

Health flexible spending account (health FSA)

During open enrollment. City of Salem will request that each eligible employee fill out an Election Form/Salary Reduction Agreement. Eligible employees will be asked to determine a contribution amount up to the maximum election allowed. The contribution amount cannot be changed unless an applicable change of status is observed (please see *Change of status*):

Maximum Election Amount: $3,050

Not to exceed the combined total election between the health FSA and limited health FSA.

During the plan year. Participants will contribute to their health FSA through pretax salary reductions. Each contribution is an equal portion of the participant's total election. Participants will have access to the entire elected amount to use for reasonably incurred medical expenses immediately following the start of the plan year – Jan. 1. Participants can use these funds throughout the entire plan year - Jan. 1 to Dec. 31. The plan year may be shortened for participants in their first year, please see *First elections*. The plan year may also differ for those participants that cease to be eligible during the plan year, please see *Termination of participation*.

For a list of eligible and ineligible expenses, please visit *benefithelpsolutions.com/pdfs/fsa_expenses.pdf* . The list is not all inclusive, if you have additional questions regarding whether something will or will not be eligible for reimbursement under your health FSA, please contact BenefitHelp Solutions customer service at 503-219-3679 or 888-398-8057.

A participant can access his or her funds by:

- Using a benefits card then substantiating the expense; or
- Paying for an eligible expense, then requesting reimbursement

Reimbursements are only available after the expense has been incurred; a medical expense is incurred at the time of medical care or service and not when the medical care or service is charged, billed for or paid.

To substantiate the use of the benefits card, a participant must:

- Provide substantiating documentation from a third party that includes type of service, name of the provider or merchant, date of service, and the out-of-pocket responsibility of the participant.

- Submit required documentation no later than the run-out period, 90 days, after the end of the plan year

To receive reimbursement for an incurred expense, a participant must:

- Complete a claim form, available from the plan administrator or online at *benefithelpsolutions.com*.
- Provide substantiating documentation from a third party that includes type of service, name of the provider or merchant, date of service, and out-of-pocket responsibility of the participant
- Submit the required claim form and documentation no later than the run-out period, 90 days after the end of the plan year (special exclusions for terminated participants; please see *After termination*).
- Submit required documentation to BenefitHelp Solutions by mail, fax, or via the online portal:

Submit online:	benefithelpsolutions.com
Submit by mail:	P.O. Box 2823
	Fargo, ND 58108
Submit by fax:	(855) 778-9837

At the end of the plan year. Participants will need to submit all outstanding claims for the current plan year within the run-out period - Mar. 31. Once all outstanding claims have been paid, participants will retain up to $610 of unused funds for claims incurred in future plan years, regardless of whether a new election is made. Any unused funds beyond $610 will be forfeited

Funds that are forfeited will be used as follows:

1. To offset any losses experienced by the City of Salem as a result of making reimbursements in excess of contributions paid by all participants;
2. To reduce the cost of administering the health FSA during the plan year and subsequent plan years; and
3. To provide increased benefits or compensation to participants in subsequent years in any weighted or uniform fashion that the plan administrator deems appropriate, consistent with applicable regulations.

All outstanding claims will need to be submitted within the run-out period, 90 days after the plan year (special exclusions for terminated participates, please see *After termination*).

For expenses outside of the period of coverage. A participant cannot be reimbursed for medical care expenses for services rendered when he or she was not an eligible employee or making contributions to his or her health FSA.

After termination. If a participant terminates his or her health FSA, he or she will have 90 days after the end of the month following the date of termination to substantiate any medical expenses incurred while he or she was a participating employee.

A participant may elect to continue his or her health FSA benefits through COBRA on a self-pay basis. This provides participants access to his or her funds through the end of the plan year for which they terminated. Only participants with a positive health FSA balance at the time of the COBRA qualifying event will be permitted to elect COBRA coverage.

Qualified reservist distribution. A participant may receive a distribution of all or a portion of the balance in his or her health FSA, if the distribution is a "qualified reservist distribution."

To qualify as a qualified reservist distribution, the following criteria must be met:

1. The participant must be a member of a reserve component (as defined by section 101 of title 3 of the United States Code) in the Army National guard, U.S. Army, Navy, Marine Corps, Air Force, Coast Guard Reserve, Air National Guard of the United States or the Reserve Corps of the Public Health Service.
2. The distributions can be made only to the reservist who, by reason of being a member of a reserve component, has been ordered or called into active duty in excess of 179 days.
3. The amount of the distribution must be for all or a portion of the balance in the employee's account.
4. The distribution must be made on or before the last day of the coverage period of the reservist.

A reservist will be allowed to cash out the unused benefits and not forfeit any unused health FSA funds.

Limited health flexible spending account (limited health FSA)

During open enrollment. City of Salem will request that each eligible employee fill out an Election Form/Salary Reduction Agreement. Eligible employees will be asked to determine a contribution amount up to the maximum election allowed. The contribution amount cannot be changed unless an applicable change of status is observed (please see *Change of status*):

Maximum Election Amount: $3,050

Not to exceed the combined total election between the health FSA and limited health FSA.

During the plan year. Participants will contribute to their limited health FSA through pretax salary reductions. Each contribution is an equal portion of the participant's total election.

Participants will have access to the entire elected amount to use for reasonably incurred dental or vision expenses immediately following the start of the plan year – Jan. 1. The plan year may be shortened for participants in their first year, please see *First elections*. The plan year may also differ for those participants that cease to be eligible during the plan year, please see *Termination of participation*.

Only reasonably incurred expenses for dental or vision care are eligible for reimbursement from the limited health FSA. Please contact BenefitHelp Solutions customer service at 503-219-3679 or 888-398-8057 for additional assistance on eligible expenses.

A participant can access his or her funds by:

1. Using a benefits card then substantiating the expense; or
2. Paying for an eligible expense, then requesting reimbursement

Reimbursements are only available after the expense has been incurred; a dental or vision expense is incurred at the time of care or service and not when the care or service is charged, billed for or paid.

To substantiate the use of the benefits card, a participant must:

1. Provide substantiating documentation from a third party that includes type of service, name of the provider or merchant, date of service, and the out-of-pocket responsibility of the participant.
2. Submit required documentation no later than the run-out period, 90 days, after the end of the plan year

To receive reimbursement for an incurred expense, a participant must:

1. Complete a claim form, available from the plan administrator or online at *benefithelpsolutions.com*.
2. Provide substantiating documentation from a third party that includes type of service, name of the provider or merchant, date of service, and out-of-pocket responsibility of the participant
3. Submit the required claim form and documentation no later than the run-out period, 90 days after the end of the plan year (special exclusions for terminated participants; please see *After termination*).
4. Submit required documentation to BenefitHelp Solutions by mail, fax, or via the online portal:

Submit online:	benefithelpsolutions.com
Submit by mail:	P.O. Box 2823 Fargo, ND 58108
Submit by fax:	(855) 778-9837

At the end of the plan year. Participants will need to submit all outstanding claims for the current plan year within the run-out period - Mar. 31. Once all outstanding claims have been paid, participants will retain up to $610 of unused funds for claims incurred in future plan years, regardless of whether a new election is made. Any unused funds beyond $610 will be forfeited

Funds that are forfeited will be used as follows:

1. To offset any losses experienced by the City of Salem as a result of making reimbursements in excess of contributions paid by all participants;
2. To reduce the cost of administering the limited health FSA during the plan year and subsequent plan years; and
3. To provide increased benefits or compensation to participants in subsequent years in any weighted or uniform fashion that the plan administrator deems appropriate, consistent with applicable regulations.

All outstanding claims will need to be submitted within the run-out period, 90 days after the plan year (special exclusions for terminated participates, please see *After termination*).

For expenses outside of the period of coverage. A participant cannot be reimbursed for dental or vision care expenses for services rendered when he or she was not an eligible employee or making contributions to his or her limited health FSA.

After termination. If a participant terminates his or her limited health FSA, he or she will have 90 days after the end of the month following the date of termination to substantiate any medical expenses incurred while he or she was a participating employee.

A participant may elect to continue his or her limited health FSA benefits through COBRA on a self-pay basis.

Qualified reservist distribution. A participant may receive a distribution of all or a portion of the balance in his or her limited health FSA, if the distribution is a "qualified reservist distribution."

To qualify as a qualified reservist distribution, the following criteria must be met:

1. The participant must be a member of a reserve component (as defined by section 101 of title 3 of the United States Code) in the Army National guard, U.S. Army, Navy, Marine Corps, Air Force, Coast Guard Reserve, Air National Guard of the United States or the Reserve Corps of the Public Health Service.
2. The distributions can be made only to the reservist who, by reason of being a member of a reserve component, has been ordered or called into active duty in excess of 179 days.
3. The amount of the distribution must be for all or a portion of the balance in the employee's account.
4. The distribution must be made on or before the last day of the coverage period of the reservist.

A reservist will be allowed to cash out the unused benefits and not forfeit any unused limited health FSA funds.

Dependent care assistance program (DCAP)

During open enrollment. City of Salem will request that each eligible employee fill out an Election Form/Salary Reduction Agreement. Eligible employees will be asked to determine a contribution amount up to the maximum allowed. The contribution amount cannot be changed unless an applicable change of status is observed (please see *Change in Status*):

Maximum Amount: $5,000

If the participant is married and resides with his or her spouse but files a separate tax return, the participant is restricted to an election under $2,500.

During the plan year. A participant will contribute to his or her DCAP through pretax salary reductions. Each contribution is an equal portion of the participant's total election. Participants will have access to the amount contributed to use for reasonably incurred dependent care expenses throughout the plan year - Jan. 1 to Dec. 31 The plan year may be shortened for participants in their first year, please see *First elections*. The plan year may also differ for those participants that cease to be eligible during the plan year, please see *Termination of participation*.

For a list of eligible and ineligible expenses, please visit *benefithelpsolutions.com/members/fsa_dependentcare.shtml#eligible*

The dependent for whom the eligible expense is applicable must meet the following qualifications:

1. Be under age 13 and:
    a. Have the same principal home address as the participant
    b. Be the participant's child, stepchild, foster child, sibling, stepsibling or a descendant of one of the preceding
    c. Not be able to provide more than half of his or her own support for the plan year
2. Be a spouse who is physically or mentally incapable of caring for himself or herself and who has the same principle home address as the participant for more than half of the year
3. Be a person who is physically or mentally incapable of caring for himself or herself, who has the same principle home address as the participant for more than half of the plan year and who is the participant's tax dependent

A participant can access his or her funds by paying for an eligible expense, then requesting reimbursement.

Reimbursements are only available after the expense has been incurred; a dependent care expense is incurred at the completion of care or service, not when the care or service is charged, billed for or paid. For example, childcare provided for the month of June and paid for June 1, will not be eligible for reimbursement until June 30.

To receive reimbursement for an incurred expense a participant must:

1. Complete a claim form, available from the plan administrator, or online at *benefithelpsolutions.com*.
2. Provide substantiating documentation from a third-party that includes the name of dependent, age and date of birth of dependent, care provider name or signature, date(s) of care, and out-of-pocket expense — for example, an itemized bill that includes all pertinent information
3. Submit the required claim form and documentation no later than the run-out period, 90 days after the end of the

plan year (special exclusions for terminated participates, please see *After termination*)

4. Submit required documentation to BenefitHelp Solutions by mail, fax, or via the online portal:

Submit online:	benefithelpsolutions.com
Submit by mail:	P.O. Box 2823 Fargo, ND 58108
Submit by fax:	(855) 778-9837

At the end of the plan year. Participants will need to submit all outstanding claims for the current plan year within the run-out period. Any unused funds will be forfeited.

Funds that are forfeited will be used as follows:

1. To offset any losses experienced by the City of Salem as a result of making reimbursements in excess of contributions paid by all participants;
2. To reduce the cost of administering the health FSA during the plan year and subsequent plan years; and
3. To provide increased benefits or compensation to participants in subsequent years in any weighted or uniform fashion that the plan administrator deems appropriate, consistent with applicable regulations.

For expenses outside of period of coverage. The participant will not be reimbursed for dependent care expenses for services rendered when he or she was not an eligible employee or making contributions to his or her DCAP.

After termination. Should a participant terminate his or her DCAP with City of Salem, the participant will have 90-days following the date of his or her termination to submit any claims incurred during the period of coverage, beginning Jan. 1 and ending on the date of termination.

Dependent care tax credit consideration. If a participant elects to participate in the DCAP, he or she may not claim any other tax benefit for the amount of his or her pretax salary reductions. However, the participant may be able to claim dependent care expenses in excess of his or her DCAP elections.

Taxation laws

This plan has been designed to meet certain requirements of existing federal tax laws. The benefits made available to participants are usually excluded from participant taxes. However, City of Salem cannot guarantee the tax treatment to any given participant because individual circumstances may produce differing results.

Appeals

Claims

If a claim is denied in whole or part for reasons beyond low funds or participant eligibility, the participant will be notified in writing by BenefitHelp Solutions (BHS) within 30 days after the date BHS received the claim. BHS may ask for an additional 15 days to handle issues outside of their control, such as an incomplete claim. Notification will include:

1. A statement of the specific reason(s) for the denial
2. Reference to the specific plan provisions(s) on which the denial is based
3. A description of any additional materials or information the participant can provide to validate the claim and an explanation of why those additional materials are necessary
4. Appropriate information on the additional actions needed by the participant if he or she would like to appeal the BHS decision

Appeal

If a claim is denied in whole or part, the participant (or authorized representative) can request additional review by the BenefitHelp Solutions Appeals Committee. The request must be submitted on a Claim Appeal Form in writing within 180 days after the participant receives notice that the initial claim was denied. If the participant fails to appeal within 180 days, he or she will lose the right to appeal the decision and must file a suit in court to proceed.

To appeal, the member must submit a Claim Appeal Form and explain, in writing, the reasons he or she feels the claim should not have been denied. The appeal should include any additional documentation that will support his or her claim. During the appeal process, the participant will have an opportunity to ask additional questions and make written comments. After the appeal has been decided, the participant will be allowed to review (upon request and at no charge) documents and other information relevant to his or her appeal.

Submit by mail: BenefitHelp Solutions
P.O. Box 2823
Fargo, ND 58108

Submit electronically: bhsclaims@healthaccountservices.com

Submit by Fax: 855-778-9837

Claims that have been denied for being submitted outside the Plan's runout period will be excluded from the Appeals review process.

Decision on internal review

The BenefitHelp Solutions Appeals Committee will review the participant's appeal within 60 days of receiving the written request for review. If the claim denial is upheld, the participant will be provided with:

1. A statement of the specific reason(s) for the decision
2. Reference to the specific plan provision(s) on which the decision was based
3. A statement of the participant's right to further review
4. Any additional guidelines or protocols that influenced the decision

If the participant disagrees with the decision made in the appeal, he or she has the right to file an action with the appropriate court challenging the decision.

Decision on external review

Participants have the right for an external review of BenefitHelp Solutions' denial of a claim, unless the denial was based on a failure to meet eligibility requirements.

To file an external appeal, please contact BenefitHelp Solutions for an external appeal form which will ask for:

1. Name, address, daytime telephone number and email address
2. A brief description of the disagreement with the internal appeal decision and any supplemental materials

Return the external appeal form within 180-days of your receipt of the internal appeal decision.

The external reviewer must notify the participant and plan administrator within 45-days of receiving the external appeal form of it's decision. The external appeal decision will be binding and may exclude any further legal action by the participant towards the plan administrator or BenefitHelp Solutions.

Duty of beneficiary and third-party recoveries

The plan requires that covered beneficiaries promptly advise the plan administrator of third-party claims and execute any assignments, liens or other documents that the plan administrator requests. The plan may withhold benefits until such documents are received.

Any beneficiary under the plan that receives a payment, whether by lawsuit, settlement or otherwise, from third parties for the costs associated with sickness or injury resulting from the acts or omissions of another person or party must reimburse the plan to the extent that the beneficiary has received payments from the plan for such sickness or injury. The plan has first lien upon any such recovery. Any recovery the plan administrator makes from such payments is subject to a deduction for reasonable attorney fees and court costs incurred by the beneficiaries in securing the third-party payments and shall be prorated to reflect that portion of the total recovery reimbursed to the plan administrator for the benefits it had paid from the plan. However, the plan's share of the recovery will not be reduced because the beneficiary has not received the full damages claimed, unless the plan administrator agrees in writing to such a reduction.

Subrogation of third parties

The plan administrator, on behalf of the plan, has the right to recover any payments made to beneficiaries whether by lawsuit, settlement or otherwise by third parties for costs associated with sickness or injury resulting from the acts or omissions of another person or party. The plan has a first lien upon any such recovery. Any recovery by the plan administrator from such payments is subject to a deduction for reasonable attorney fees and court costs incurred by the beneficiaries in securing the third-party payments and shall be prorated to reflect that portion of the total recovery reimbursed to the plan administrator for the benefits it had paid from the plan. However, the plan's share of the recovery will not be reduced because the beneficiary has not received the full damages claimed, unless the plan administrator agrees in writing to such a reduction.

HIPAA privacy rights: use and disclosure of protected health information

Except for certain permitted uses and disclosures, the privacy rule issued by the federal government prohibits the cafeteria plan from using or disclosing protected health information about a participant that is created or received by the cafeteria plan without written authorization. For additional information about privacy rights, please either refer to the cafeteria plan's privacy notice or contact the cafeteria plan's privacy official:

City of Salem
555 Libert St. SE, Room 225
Salem, OR 97301

If a participant would like to authorize the cafeteria plan to use or disclose protected health information (PHI) in a manner that is not otherwise permitted, City of Salem must obtain a signed and completed authorization form.

Permitted uses and disclosures

The cafeteria plan is permitted under the privacy rule to use or disclose a participant's PHI without authorization for the following purposes:

1. Healthcare treatment
2. Payment for healthcare
3. Healthcare operations
4. Other specifically permitted exceptions, such as disclosures to assist disaster relief, etc.

For a complete list of permitted exceptions, please refer to the cafeteria plan's privacy notice or contact the cafeteria plan's privacy official.

Disclosures to City of Salem

After City of Salem has certified to the cafeteria plan that it is in compliance with the privacy rule, the cafeteria plan may disclose PHI to City of Salem without participant authorization to the extent that PHI is absolutely necessary for City of Salem to perform cafeteria plan administration functions. The cafeteria plan may not disclose any PHI that is not necessary to fulfill administration functions. City of Salem is also not allowed to disclose any PHI for purposes of any employment-related actions in connection with any other employee benefit provided. To the extent that PHI is disclosed to City of Salem, City of Salem will:

1. Not use or further disclose PHI other than as permitted or required by the official cafeteria plan document or as required by law
2. Ensure that any agents to whom City of Salem provides PHI (or certain electronic protected health information or "electronic-PHI") received from the cafeteria plan agree to the same restrictions and conditions that apply to City of Salem with respect to PHI
3. Not use or disclose PHI for employment-related actions and decisions unless authorized by the participant
4. Not use or disclose PHI in connection with any other benefit provided by City of Salem unless authorized
5. Report to the cafeteria plan's privacy officer any misuse or improper disclosure of PHI
6. Make PHI available to the participant in accordance with the requirements of the privacy rule
7. Make PHI available to each participant for amendment and incorporate any amendments to PHI in accordance with the requirements of the privacy rule
8. Make available to each participant, upon request, an accounting of disclosures in accordance with the requirements of the privacy rule
9. Make internal practices, books and records relating to City of Salem's use and disclosure of PHI available to the Secretary of Health and Human Services for the purposes of determining the cafeteria plan's compliance with HIPAA
10. Make available to each participant, upon request, an accounting of disclosures in accordance with the requirements of the privacy rule
11. If feasible, return or destroy all PHI received from the cafeteria plan that City of Salem still maintains in any form and retain no copies of the PHI when the PHI is no longer needed for the purpose for which the disclosure was made, or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

City of Salem may only disclose PHI (or certain electronic-PHI) to the following employees and may only do so to the extent that the employees perform cafeteria plan administration functions:

1. The privacy official
2. Employees in City of Salem's human resources department
3. Employees in City of Salem's office of general counsel
4. Any other class of employees designated in writing by the privacy official

If an employee does not comply with the requirements of the privacy rule, then City of Salem may apply appropriate sanctions to the employee to ensure compliance with the privacy rule.

General information

Name	City of Salem's Cafeteria Plan
Plan number	501
Effective date	Jan. 1, 2023
Plan year	Jan. 1 to Dec. 31
Type of plan	Welfare Plan
Governing laws	State of Oregon

Administrator information

City of Salem
555 Libert St. SE, Room 225
Salem, OR 97301

Tax identification number (EIN) 93-6002249

Agent for service of legal process

City of Salem
555 Libert St. SE, Room 225
Salem, OR 97301

Name fiduciary

Named fiduciary for the cafeteria plan: City of Salem

Third-party administrator information

BenefitHelp Solutions
P.O. Box 2823
Fargo, ND 58108

Customer Service	(855) 378-0917
Customer Service email	customerservice@benefithelpsolutions.com
Submit an appeal	bhsclaims@healthaccountservices.com

The plan administrator appoints BenefitHelp Solutions to keep the records for the plan and to be responsible for the administration of the plan. However, the Appeals Committee acts on behalf of the plan administrator with respect to appeals. BenefitHelp Solutions will answer any questions that you may have about our plan. You may contact the BenefitHelp Solutions at the above address for any further information about the plan.

Funding and type of plan administration

This is a contract administration plan. A third-party administrator processes claims for the plan. A health insurance issuer is not responsible for the financing or administration (including payment of claims) of the plan.

All of the amounts payable under this plan can be paid from the general assets of the City of Salem, but premium payment benefits are paid as provided in the applicable insurance policy.

Nothing herein will be construed to require the City of Salem or the plan administrator to maintain any fund or to 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 City of Salem from which any payment under this plan can be made. There is no trust or other fund from which benefits are paid. While the City of Salem has complete responsibility for the payment of benefits out of its general assets (except for premium payment benefits paid as provided in the applicable insurance policy), it may hire an unrelated third-party paying agent to make benefit payments on its behalf.

[None]Qualified medical child support order

The medical insurance plan and the health FSA will provide benefits as required by any qualified medical child support order (QMCSO), as defined in ERISA § 609(a). The plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the plan administrator.

Women's Health and Cancer Rights Act of 1998 (WHCRA)

The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy. This law applies generally both to persons covered under group health plans and persons with individual health insurance coverage. But WHCRA does not require health plans or issuers to pay for mastectomies. If a group health plan or health insurance issuer chooses to cover mastectomies, then the plan or issuer is generally subject to WHCRA requirements.

The Genetic Information

Nondiscrimination Act of 2008 (GINA)

The Genetic Information Non-Discrimination Act (GINA) prohibits discrimination by health insurers and employers based on individuals' genetic information. Genetic information includes the results of genetic tests to determine whether someone is at increased risk of acquiring a condition in the future, as well as an individual's family medical history. GINA imposes the following restrictions: prohibits the use of genetic information in making employment decisions, restricts the acquisition of genetic information by employers and others, imposes strict confidentiality requirements, and prohibits retaliation against individuals who oppose actions made unlawful by GINA or who participate in proceedings to vindicate rights under the law or aid others in doing so.

Health Information Technology for Economic and Clinical Health Act (HITECH Act)

The Health Information Technology for Economic and Clinical Health Act was passed as part of the American Recovery and Reinvestment Act of 2009 to strengthen the privacy and security protection of health information and to improve the workability and effectiveness of HIPAA Rules. HITECH defines an EHR as "electronic record of health-related information on an individual that is created, gathered, managed and consulted by authorized healthcare clinicians and staff."

[None]The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

This new law amends the Employee Retirement Income Security Act (ERISA), the Public Health Service Act (PHSA) and the Internal Revenue Code (IRC) and applies to all ERISA group health plans and to health insurers that provide insurance coverage to group health plans. In general, this new law requires group health plans that provide mental health or substance use disorder benefits to provide such benefits on par with medical-surgical benefits.

Medical insurance plan documents and information

This Summary Plan Description (SPD) does not describe the medical insurance plan. Consult the medical insurance plan document and the separate summary plan description for the medical insurance plan.