

## Summary Plan Description

**Note to Employer: The United States Department of Labor (DOL) requires this summary or a copy of it to be distributed to each eligible Employee.**

Plan Sponsor (Employer), Plan Administrator, and Agent for Legal Service			
Employer/Plan Sponsor Name:	City of Ames		
Contact Name:	Krista Hammer	Phone Number:	515-239-5293
Employer Address:	515 Clark Ave		
		Federal Tax ID:	42-6004218
	Ames, IA 50010	ERISA Plan Number:	N/A
<i>Plan Administrator accepts service of legal process.</i>			
Employer's Plan Name: City of Ames Flexible Benefits Plan			
Group Name:	City of Ames		
Plan Year:	See below	Client TASC ID:	4819-0446-5507
Healthcare FSA Carryover Maximum:	\$660	Plan Runout End Date:	02/28/26
Dependent Care FSA Carryover Maximum:	\$0	Plan Runout End Date:	02/28/26

### PURPOSE

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

BENEFITS OFFERED TO EMPLOYEES	Plan Year	Maximum Participant Salary Reduction	Minimum Participant Salary	Healthcare FSA Carryover Maximum Amount or - Grace Period End Date
Healthcare FSA	1/1/25 - 12/31/25	\$3,300.00	\$100.00	Carryover Max- \$660
Dependent Care FSA (day care expenses)	1/1/25 - 12/31/25	\$5,000.00	\$100.00	02/28/2026
Medical or Medical-Related Premiums (Medical/Dental/Vision)	7/1/25 - 6/30/26	N/A	N/A	N/A

This Flexible Benefits Plan allows you to reduce your taxable income in direct proportion to (a) your contribution to the cost of your elected benefits and (b) your contribution to any account-based tax advantaged plan or fringe benefit plan offered by your Employer.

## ELIGIBILITY REQUIREMENTS

The benefits offered above are available to the following Employees as stipulated below:

Full or part-time Employees regularly scheduled to work at least <b>20 hours</b> per week:		Eligible
<b>Waiting Period:</b>	After <b>30 days</b> of continuous employment an Employee will become plan-eligible. Coverage begins on the Effective Date of Coverage.	
<b>Effective Date of Coverage:</b>	Plan coverage begins on the first day of the month after the Waiting Period ends.	
<b>Employee Entry:</b>	Annually at open enrollment and upon satisfying the plan eligibility requirements.	

**This plan defines a plan-eligible Employee to be an individual classified by the Employer as a common-law employee of the City of Ames who is on the City of Ames W-2 payroll.** Employees do not include self-employed individuals, partners in a partnership, or more-than-2% shareholders in a Subchapter S corporation.

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

**New Employees.** If your employment begins after the plan's Effective Date, you will be eligible to participate on the Employee Entry date noted above, following the date you satisfy the Employee Waiting Period and Eligibility Requirements stated above.

**Re-employment of Former Employees.** A former Employee rehired within thirty (30) days of termination will immediately be reinstated into their original elections.

A former Employee rehired after thirty (30) days of termination may make new elections after re-satisfying plan eligibility requirements.

**Age Requirement.** No maximum age requirement may be imposed for participation in this Flexible Benefits Plan.



## GENERAL INFORMATION

This Flexible Benefits Plan allows you to pay your cost for the benefits you elected through a Salary Reduction Agreement. This lowers your federal and state taxes. Under this Flexible Benefits Plan two types of benefit plans offered by your Employer: 1) premium benefits and 2) reimbursement benefits. Premium benefits are made to secure your participation in your elected plans. These are payments made from your employer's general assets to an insurance company or a third-party administrator. Reimbursement benefits are benefits paid under an agreement to reduce your salary by the amount you elected and pay you tax free benefits for certain qualified events such as healthcare and dependent care expenses.

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

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

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

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

**No Continued Employment.** No provisions either of the plan or of this SPD shall grant any Employee any rights of continued employment with the Employer or shall in any way prohibit changes in the terms of employment of any Employee covered by the plan.

**Non-Assignment of Benefits.** No Participant or beneficiary may transfer, assign or pledge any plan benefits except as may be required pursuant to:

- (a) a "Qualified Medical Child Support Order" (which provides for plan coverage for an alternate recipient),
- (b) other applicable law, or (c) electronic payment made directly to a healthcare provider.

## CONTRIBUTIONS AND ENROLLMENT

**Participant Contributions.** By participating in the plan, you agree to have your annual compensation reduced by the total cost of the plan benefits you elected. The City of Ames reserves the right to reduce the participant's medical and/or dependent care spending account annual election amount(s) in the event the plan fails nondiscrimination testing.

**Employer Contributions and Enrollment Elections.** At its election, your Employer may pay part of the insurance premiums or other qualified benefits made available through this plan. Your employer will provide annual enrollment materials at the beginning of each plan year, or at the time of your enrollment in this plan. The annual enrollment materials will include: (1) the amount of any employer contributions for the various plans offered by the Employer that allow you to make pre-tax contributions, (2) the rules defining how the employer contributions may be used, and (3) the enrollment procedures to make annual elections for your pretax contributions. These enrollment materials are incorporated in this Summary Plan Description by reference. If the terms of the annual enrollment materials and this SPD are in conflict, the annual enrollment materials will control for the plan year for which they were provided.

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

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

## BENEFITS AND QUALIFYING CHANGE IN STATUS EVENTS

The laws governing Flexible Benefits Plans generally do not allow you to change your benefit and contribution elections during a Plan Year (except for Health Savings Accounts; see below). Your elections are irrevocable and any balance in your account at the close of the Plan Year is forfeited and becomes the property of your Employer (refer to your open enrollment materials if your plan has a Grace Period or a Carryover); this irrevocable election rule does not apply if you experience a qualifying change in status event, in which case the election change requested must be on account of and consistent with the qualifying event.

Any request to change your election must be submitted in writing within 45 days of any applicable qualifying event. The new benefit elections may start only after your change in status has taken place and the new paperwork has been filed.

This plan is intended to allow any change in status event that is allowed by the IRS. A qualifying change in status event may be one of the following:

- A change in legal marital status (marriage, death of spouse, divorce, legal separation and annulment).
- The adoption, birth, or death of a child or dependent.
- Dependent satisfies or ceases to satisfy dependent eligibility requirements.
- The change in employment status of you, your spouse or dependent.
- Change in your residence.\*
- Beginning or ending adoption proceedings.
- Automatic changes upon cost increases or decreases.\*
- Significant cost increases.\*
- Significant curtailment of coverage.\*
- Addition or elimination of similar benefits package option.\*
- Change in coverage of a spouse or dependent under an employer plan.\*
- FMLA.
- HIPAA special enrollment rights.\*
- COBRA qualifying event.
- Loss of group health coverage sponsored by governmental or education institution.\*
- A judgment, decree or order requiring coverage for a spouse or child.



- Medicare or Medicaid entitlement.
- Termination of Medicaid or State Children's Health Insurance Program (SCHIP) coverage.\*
- Eligibility for Employment Assistance under Medicaid or SCHIP.\*
- Exchange Event – A loss of eligibility under the terms of the plan due to a reduction in hours (less than 20) – even when the Employer allows the coverage to continue in effect during the ‘Stability Period’ to satisfy the Affordable Care Act coverage requirements.\*
- Exchange Event – Exchange enrollment during an Exchange open enrollment period or special enrollment period.\*

*\*These qualifying change in status events do not apply to the Healthcare FSA.*

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

## REIMBURSEMENT ACCOUNTS

If the BENEFITS OFFERED TO EMPLOYEES Section of this Summary Plan Description lists Healthcare FSA and Dependent Care FSA Account then your plan includes that reimbursement account.

The *Participant Reference Guide*, incorporated by express reference into this Summary Plan Description, includes all the information you need to access your reimbursement accounts and submit requests for reimbursement. By signing into your online account, you may access information about your reenrollment, available funds, annual election, total contributions, and total reimbursements. These accounts provide tax-free benefits for healthcare, dependent daycare and/or non-employer sponsored health insurance premiums in accordance with IRS guidelines and protocols.

**Healthcare Flexible Spending Account (FSA).** All healthcare expenses must be (a) for medical care as defined in Code Section 213(d) which is rendered or received during the Plan Year, (b) incurred by an Accountholder, Accountholder's spouse, or dependent, (c) not otherwise taken as a medical deduction by a taxpayer and (d) not covered under any other benefit plan or account. Services and supplies must be for diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. Services and supplies that are beneficial "to an individual's general health" are not covered unless they are determined by a physician to be necessary to treat or alleviate a specific physical or mental illness. Amounts paid for menstrual care products shall be treated as paid for medical care. Over-the-counter (OTC) drug products no longer require a prescription and can be reimbursed under this Plan.

**Dependent Care FSA.** This account provides employees with tax free dependent care assistance only when the assistance is necessary for the Participant to leave the home to engage in activity directly related to his/her employment. Qualified expenses under the Dependent Care FSA include any expenses that you could take as a credit against tax on your income tax form for the care of a Qualified Person. Benefits are provided only to the extent of your payroll deduction on the date the RFR is processed. The tax laws further limit how much you may contribute to this account.

Under the law and the terms of the plan, you may defer no more than the lesser of your actual (or, if you are married and if less, your spouse's) income for the year or \$5,000 per year to this Program. A married Participant who files separate tax returns is limited to \$2500 per year.

## QUALIFIED RESERVIST DISTRIBUTION

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

## QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

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

## LEAVE OF ABSENCE

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

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

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

- (1) Prepay. Your share of contributions due during your leave may be paid either pre-tax or after-tax before your leave begins provided any pre-tax pre-payments do not fund coverage for the next Plan Year.
- (2) Catch-up. Your Employer may advance your share of contributions while you are on leave. Upon your return from leave, your Employer may recover the advanced amounts on either a pre-tax or after-tax basis. Check with your Employer to determine if this option is available under your plan.

**Non-FMLA Leave.** If you go on an unpaid leave that affects eligibility, then the Change in Status rules will apply.

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



## TERMINATION OF PARTICIPATION

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

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

**Benefit Account Coverage.** When participation has terminated, you are eligible to incur Qualified Expenses against your positive account balance\* through the date your eligibility ends for your benefit account, as indicated in the chart below.

\*Positive account balance: Your annual election less prior reimbursements for a Healthcare FSA. If Carryover is offered by your Employer, funds that carried forward into your current Healthcare FSA will be included. The positive account balance for any other benefit in the chart below is your total contributions less prior reimbursements.

Benefit Account	Paid Coverage Period Ends	Eligibility Ends
Healthcare FSA	Date of Termination	Date of Termination
Dependent Care FSA	Date of Termination	Date of Termination

**Requests for Reimbursement (RFR).** When your participation has terminated, you may submit eligible requests for reimbursement (RFR) through your runout period as noted in the Request for Reimbursement (RFR) Procedure section of this document.

**Carryover.** As a terminated Participant, you are not eligible for a Carryover (when offered by your Employer) unless you are an active Participant in the plan and your Paid Coverage Period continues through the last day of the Plan Year. This means, if you term during a calendar year, you must enroll in COBRA and keep your payments current in order to receive any eligible Carryover amount from the previous plan year.

If you continue to be employed, yet you do not enroll in the future plan year, you will be eligible for Carryover funds up to the allowed maximum from the previous year you enrolled in the plan.

## REQUEST FOR REIMBURSEMENT (RFR) PROCEDURE

If you have elected reimbursement coverage, you may submit eligible requests for reimbursement (RFR) through the Plan Runout End Date as indicated on page one of this document. A terminated Participant may submit eligible requests for reimbursement (RFR) through the runout period for terminated Participants as indicated below.

Runout Period for Terminated Participants <i>(Only one option, as selected below, is applicable to your plan.)</i>		
<input checked="" type="checkbox"/>	<u>Plan Runout Period</u>	As a terminated Participant, you may submit eligible requests for reimbursement (RFR) through the Plan Runout End Date as indicated on page one of this document.
<input type="checkbox"/>	<u>Not Applicable</u>	As a terminated Participant, you may submit eligible requests for reimbursement (RFR) through your individual runout period of ____ days after your eligibility ends.

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



## REIMBURSEMENT DENIALS

**Medical, Dental and Vision Insurance Benefits.** The applicable insurance company will determine your RFR in accordance with its RFRs procedures.

**Reimbursements under the Healthcare FSA or Dependent Care FSA.** The RFR procedure described below will apply if (a) a RFR under the Healthcare FSA or Dependent Care FSA components of the salary reduction plan is wholly or partially denied, or (b) you are denied a benefit under the salary reduction plan due to an issue germane to your coverage under the plan.

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

Notification of a denied RFR will detail:

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

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

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

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





## NOTICES REQUIRED BY LAW

**Special Rights on Childbirth.** Under Federal law, group health plans may not restrict benefits for any hospital length of stay in connection with childbirth for (either mother or newborn child) to less than 48 hours following a vaginal delivery or less than 96 hours following a caesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the above period. In any case, under Federal law a provider may not be required (by plan or insurer) to obtain authorization from the plan for prescribing a length of stay up to 48 hours (or 96 hours).

## CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

If you elect to participate under the Healthcare FSA and are considered a Participant on the day before experiencing a qualifying event, COBRA continuation ends on the last day of the Plan Year in which the qualifying event occurred.

Further, COBRA continuation coverage will not be offered if on the day of your qualifying event, the amount of your annual election less any reimbursed payments is less than the amount of premium required to continue the Healthcare FSA Plan until the end of the Plan Year. COBRA continuation under an excepted Healthcare FSA Plan is available until the end of the Plan Year in which the qualifying event occurs.

A Participant who experiences a qualifying event is considered a qualified beneficiary. When a qualified beneficiary experiences a qualifying event, they will be sent a notification explaining their rights to elect COBRA continuation coverage. Your Employer has 14 days from the date of the loss of coverage in which to send the COBRA Election Notice. A qualified beneficiary who wishes to continue coverage must notify the Plan Administrator of their desire to continue coverage within sixty days of either the date of notification or date of loss of coverage, whichever is later. If the Plan Administrator does not receive notification within this time period, you will lose your right to elect continuation coverage. Finally, qualified beneficiaries who elect continuation coverage are responsible for premiums back to the date that termination from the plan would have occurred.

COBRA continuation is available until the end of the Plan Year in which the qualifying event occurs. The premium charged for the continuation coverage may be 102% of your monthly contribution. The first month's premium is due no later than 45 days after the election is made. The Employer may require the COBRA payments be apportioned for the remainder of the Plan Year. Listed below are qualifying events:

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

### COBRA Coverage and Carryover Benefits

A participant terminated prior to end of the plan year who does not continue coverage under COBRA through the end of the plan year will not be eligible for carryover. Likewise, a participant terminated prior to the end of the plan year who continues coverage under COBRA through the end of the plan year will be eligible for carryover. COBRA participants who qualify for carry-over into the new plan year will not be eligible to make contributions in the new plan year. Access to carry-over funds in the proceeding plan year will only be available until the end of the participant's COBRA eligibility period.

### COBRA Questions

If you have questions about your COBRA continuation coverage, you should contact the City's Human Resources Office at 515-239-5199 or you may contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA); addresses and phone number of Regional and District EBSA Offices are available through EBSA's website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).