Plan Document and Summary Plan Description for the City of Tifton

- Your Dental & Vision Benefits
- Your Life Insurance and AD&D Benefits
- Your Disability Benefits
- Flex Spending Account (FSA)

EFFECTIVE DATE: 05/01/2017

Introduction

City of Tifton (the "Employer" or "Company") is pleased to offer benefits through the City of Tifton. These benefits are a valuable and important part of your overall compensation package.

*This booklet provides important information about the Benefit Program(s) covered under the Plan. It serves as the Plan document and the Summary **Plan** Description ("SPD') for the City of Tifton ("the Plan). It is written to comply with the written plan document and disclosure requirements under the Employee Retirement Income Security Act ("ERISA) of 1974, as amended.*

The "Benefit Programs" covered by this Plan are shown in Appendix A. For fully insured Benefit Programs, the insurance contracts or policies (including amendments and riders), plan descriptions, benefit summaries, schedule of benefits and other descriptive documents relating to each Benefit Program (collectively, the "insurance certificates") are incorporated herein by reference only to the extent they are the source of eligibility, benefits, claims procedures, or other substantive provisions of the Benefit Programs. This booklet is not intended to give any substantive rights to benefits that are not already provided by the insurance certificate for an insured benefit. If the terms of this booklet conflict with the substantive terms of an insurance certificate for an insured Benefit Program, the terms of the insurance certificate will control, unless otherwise required by law.

This Plan document/SPD replaces all previous booklets you may have in your files. Be sure to keep this booklet in a safe and convenient place for future reference. We encourage you to read this booklet and insurance certificates and become familiar with your benefits. You may also wish to share this information with your enrolled family members.

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Plan Overview

The Plan provides benefits to eligible employees and their dependents through each Benefit Program listed in Appendix A. Fully insured benefits are payable solely by the Insurer listed for the respective Benefit Program.

Your Eligibility

You are eligible for the Benefit Program(s) shown in Appendix A if you are a full-time active employee normally scheduled to work a minimum of 32 hours per week.

Unless otherwise communicated to you in writing by the Company, the following individuals are not eligible for benefits: part-time employees, employees of a temporary or staffing firm, payroll agency or leasing organization, persons hired on a seasonal or temporary basis, independent contractors and other individuals who are not on the Employer payroll, as determined by the Employer.

The Employer's determination of eligibility is conclusive and binding for Plan purposes. No reclassification of a person's status, for any reason, by a third party (whether by a court, governmental agency or otherwise) will change a person's eligibility for benefits under the Plan.

Eligible Dependents

The definition of eligible dependents and other provisions, such as whether you may enroll your eligible dependents in a Benefit Program, are defined in the insurance certificates for each Benefit Program. Those provisions, and the definition of a dependent for each Benefit Program, are incorporated by reference herein.

Unless otherwise defined by the insurance certificate for a Benefit Program, your eligible dependents include:

- your legal spouse;
- your child under age 26 regardless of financial dependency, residency with you, marital status, or student status;

For purposes of the Plan, your child includes:

- your biological child;
- your legally adopted child (including any child lawfully placed for adoption with you);
- your stepchild;
- a foster child who has been placed with you by an authorized placement agency or by judgment decree or other court order;
- a child for whom you are the court-appointed legal guardian;
- an eligible child for whom you are required to provide coverage under the terms of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN).

If you have any questions regarding dependent coverage under a Benefit Program, check with the Insurer or Claims Administrator. It is your responsibility to notify the Employer if your dependent becomes ineligible for coverage.

An eligible dependent does not include a person enrolled as an employee under the Plan or any person who is covered as a dependent of another employee covered under the Plan. If you and your spouse are both employed by the Employer, each of you may elect your own coverage (based on your own eligibility for benefits) or one of you may be enrolled as a dependent on the other's coverage, but only one of you may cover your dependent children.

When Coverage Begins

To be eligible for a Benefit Program, you must satisfy the eligibility requirements described for that Benefit Program in the applicable insurance certificates and other materials provided for that Benefit Program. Unless otherwise stated in those materials, your coverage begins the first of the month following 60 days of employment.

Certain benefits, such as disability or life insurance, may require you to be actively at work in order to be initially eligible for a Benefit Program and for any change in coverage to take effect. See the materials provided by your Insurer to determine when this applies to you.

If you terminate employment and are subsequently rehired, you will be treated as a new employee and will need to satisfy all eligibility requirements to be covered under the Plan.

Unless stated otherwise in your insurance certificates, coverage for your eligible dependents begins on the same day as your initial eligibility provided you timely enroll your dependents in coverage. If you acquire a new dependent through marriage, birth, adoption or placement for adoption, you can add your new dependent to your coverage as long as you enroll the dependent within 30 days of the date on which they became eligible. If you wait longer than 30 days, you may be required to wait until the Plan's next open enrollment period to enroll your new dependent for coverage.

Proof of Dependent Eligibility

The Employer reserves the right to verify that your dependent is eligible or continues to be eligible for coverage under the Plan's Benefit Programs. If you are asked to verify a dependent's eligibility for coverage, you will receive a notice describing the documents that you need to submit. To ensure that coverage for an eligible dependent continues without interruption, you must submit the required proof within the designated time period. If you fail to do so, coverage for your dependent may be canceled.

Your Contribution for Coverage

Each year, the Employer will evaluate all costs and may adjust the cost of coverage during the next annual enrollment. Any required contribution amount will be provided to you by the Employer in your enrollment materials. You may also request a copy of any required contribution amounts from the Plan Administrator.

For most benefits you pay the employee cost of Plan premiums through pre-tax payroll deductions each pay period; however, some Benefit Programs may require premiums to be paid with after-tax dollars.

You must elect coverage for yourself in order to cover your eligible dependents. Your coverage for certain Benefit Programs may also be subject to deductibles, copayments, coinsurance, or other fees as described in the materials for the coverage you select.

Enrolling for Coverage

Initial Enrollment

As a newly eligible employee, you will receive an Election Form and enrollment information when you first become eligible for benefits. For each Benefit Program, you will need to make your coverage elections by the deadline shown in your enrollment materials. When you enroll in the Plan, you authorize the Employer to deduct any required premiums from your pay through salary reduction. If you do not enroll for coverage when initially eligible, you will be deemed to have elected no coverage or the default coverage designated by the Employer for a Benefit Program.

The elections you make will remain in effect until the next April 30, unless a permitted election change event occurs (see below). Your insured benefits may have a different coverage period. Your enrollment materials and Election Form will tell you if a different 12-month coverage period applies to your elections for an insured benefit. After your initial enrollment, you will enroll during the designated annual open enrollment period.

Annual Open Enrollment Period

Each year during a designated open enrollment period, you will be given an opportunity to make your elections for the upcoming year. Your enrollment materials and Election Form will provide the options available to you and your share of the premium cost, as well as any default coverage you will be deemed to have elected if you do not make an election by the specified deadline. In general, the elections you make will take effect on May 1 and stay in effect through April 30, the Plan Year, unless you have a qualifying change in status. The Plan Year may differ from the policy year of an insured benefit. Your enrollment materials and Election Form will tell you if a different 12-month coverage period applies to your elections for an insured benefit. Also, you should refer to the insurance certificate provided by the Insurer for more information on how your benefits are affected by the policy year, including whether your deductible and out-of-pocket expenses accumulate over the Plan Year, policy year or other 12-month period.

Special Enrollment Rights

You may enroll for coverage outside of the Plan's initial and annual open enrollment periods if you experience a special enrollment event, as described below. Special enrollment rights apply to the Plan's medical benefits. These rights, however, may not apply all Benefit Programs (for example, these rights do not apply to Benefit Programs that are "excepted benefits" under HIPAA). You should review your insurance certificate and check with the Plan Administrator if you have questions about enrolling in a Benefit Program.

- If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health coverage is in effect, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward the other coverage). However, you must request enrollment within 30 days after the other coverage ends (or after the employer stops contributing toward the other coverage).
- If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this Plan

if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after coverage ends under Medicaid or a state CHIP.

- If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.
- If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state CHIP with respect to coverage under this Plan, you may be able to enroll yourself and your dependents in this Plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

You will need to provide documentation of your special enrollment event in order to enroll outside of an initial or annual open enrollment period. Contact the Plan Administrator to determine what information you will need to provide.

Code Section 125 Status of Plan

This Plan is designed and administered in accordance with Section 125 of the Internal Revenue Code and underlying regulations. This enables you to pay your share of premiums for certain Benefit Programs on a pre-tax basis, as permitted by the Employer. Review your election and enrollment materials to determine which Benefit Programs permit pre-tax premium payments and are subject to the Section 125 rules. Pre-tax dollars come out of your pay before federal income and Social Security taxes are withheld (and, in most states, before state taxes are withheld). This gives your contributions a special tax advantage and lowers the actual cost of participating in the Plan to you. Neither the Employer nor any fiduciary under the Plan will in any way be liable for any taxes or other liability incurred by you by virtue of your participation in the Plan.

Because of this favorable tax-treatment, there are certain restrictions on when you can make changes to your elections for Section 125 benefits. Generally, your elections stay in effect for the Plan Year (or other 12-month period of coverage for an insured benefit, as designated in your enrollment materials and election form) and you can make changes only during an annual open enrollment period. However, depending on the Plan's rules for mid-year election change events, you may be able to change your elections if a permitted election change event occurs as described below.

Permitted Election Change Events

The elections you make under the Plan are generally irrevocable during the Plan Year (or other 12-month coverage period that applies to a Benefit Program, as indicated in your enrollment and election materials). This means, for example, that once you have elected how much pre-tax income you will use to pay for the Plan's Benefit Programs, you are locked into that election until the next annual enrollment period. However, there are certain limited situations that allow you to change your Plan elections outside of the annual enrollment period, depending on the Plan's eligibility rules for a Benefit Program. You may change your elections if a "permitted election change event" occurs and you make an election change that is consistent with the event, as determined by the Plan Administrator.

This Plan allows participants to change their elections to extent permitted by applicable law and approved by the Plan Administrator. Depending on the Plan's eligibility rules for a Benefit Program, a "permitted election change event" that may allow you to change your election includes the following events:

- a change in your legal marital status, including marriage, divorce, death of spouse, legal separation or annulment
- a change in the number of dependents, including birth, adoption, placement for adoption or death of a dependent
- a change in employment status for you, a spouse or a dependent that affects eligibility
- a change in a dependent child's eligibility
- a change in residency that would impact eligibility (for example, moving out of a plan's coverage area)
- the cost of a Benefit Program significantly changes
- coverage under a Benefit Program is significantly curtailed or ceases
- a new Benefit Program or other coverage option is added or coverage under an existing Benefit Program is significantly improved
- your spouse's or dependent's plan has a different enrollment period and you need to make a change to account for that other coverage
- you, your spouse or your dependent loses group coverage sponsored by a governmental or educational institution
- your change corresponds with a HIPAA special enrollment right (described above)
- you, a spouse or dependent is eligible for COBRA continuation coverage under the Plan (if applicable) and you need to increase your payments for the coverage
- a court order, such as a QMCSO or NMSN, mandates coverage for an eligible dependent child
- you, a spouse or a dependent enrolls in Medicare or Medicaid
- you take an FMLA leave (if applicable)
- a change in your employment status to less than 30 hours of service per week on average even if the reduction does not result in loss of Plan eligibility
- eligibility for a special enrollment period to enroll in a qualified health plan (QHP) through the Marketplace or seeking to enroll in a QHP during the Marketplace's annual open enrollment period
- any other election change event recognized by the IRS and permitted by the Plan Administrator

Also, if the cost of a Benefit Program changes by an insignificant amount during a coverage period, the Plan Administrator may automatically make a corresponding change to your election. You should report an election change event to the Plan Administrator as soon as possible, but no later than 30 days after the event occurs. Contact the Plan Administrator if you have questions about when you can change your elections.

When Coverage Ends

Except as otherwise provided in the insurance certificate, your coverage under this Plan ends on the last day you are actively employed, unless benefits are extended, such as when you take an approved leave of absence.

Coverage for your covered dependents ends on the date your coverage ends, or, if earlier, on the date your dependent is no longer eligible for coverage under the Plan.

Coverage will also end for you and your covered dependents as of the date the Employer terminates this Plan or, if earlier, the effective date you request coverage to be terminated for you and/or your covered dependent.

If your coverage under the Plan ends for reasons other than the Employer's termination of all coverage under the Plan, you and/or your eligible dependents may be eligible to elect to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) as described below.

Cancellation of Coverage

If you fail to pay any required premium for coverage under a Benefit Program, coverage for you and your covered dependents will be canceled for that Benefit Program and no claims incurred after the effective date of cancellation will be paid.

Rescission of Coverage

Coverage under the Plan may be rescinded (canceled retroactively) if you or a covered dependent performs an act, practice or omission that constitutes fraud, or you make an intentional misrepresentation of material fact as prohibited by the terms of the Plan. A rescission of coverage is an adverse benefit determination that you may dispute under the Plan's claims and appeals procedures. If your coverage is being rescinded due to fraud or intentional misrepresentation of material fact, you will receive at least 30 days' advance written notice of the rescission. This notice will outline your appeal rights under the Plan. Benefits under the Plan that qualify as "excepted benefits" under HIPAA are not subject to these restrictions on when coverage may be rescinded. Some types of retroactive terminations of coverage are permissible even when fraud or intentional misrepresentation are not involved. Coverage may be retroactively terminated for failure to timely pay required premiums or contributions as required by the Plan.

Also, coverage may be retroactively terminated to the date of your divorce if you fail to notify the Plan of your divorce and you continue to cover your ex-spouse under the Plan. Coverage will be canceled prospectively for errors in coverage or if no fraud or intentional misrepresentation was made by you or your covered dependent.

The Plan reserves the right to recover from you and/or your covered dependents any benefits paid as a result of the wrongful activity that are in excess of the contributions paid. In the event the Plan terminates or rescinds coverage for gross misconduct on your behalf, continuation coverage under COBRA may be denied to you and your covered dependents.

Coverage While Not at Work

In certain situations, coverage may continue for you and your dependents when you are not at work, so long as you continue to pay your share of the cost. If you take an unpaid leave of

absence, you will need to make payment arrangements prior to the start of your leave. You should discuss with Human Resources or your supervisor what options are available for paying your share of costs while you are absent from work.

If You Take a Leave of Absence (FMLA)

If you take an approved FMLA leave of absence, your coverage will continue for the duration of your leave, as long as you continue to pay your share of the cost as required under the Employer's FMLA Policy. Coverage for other benefits can be found in the insurance certificates for the respective Benefit Programs in which you have enrolled.

If You Take a Military Leave of Absence

If you are absent from work due to an approved military leave, coverage may continue for up to 24 months under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) starting on the date your military service begins. Coverage for other benefits can be found in the insurance certificates furnished by the Insurer for the respective Benefit Programs in which you have enrolled and will be governed by the provisions of USERRA.

Your Health Care Coverage

You should refer to the materials provided by the Insurer for information concerning any limitations, waiting periods before coverage begins, maximum benefits payable, when coverage ends, exclusions, age reductions, or reductions for other benefits that may apply.

The following health care Benefit Programs are fully insured and administered by the Insurer(s) listed in Appendix A:

- Dental
- Vision

Participation

To become a participant in the above Benefit Program(s), you must meet all eligibility requirements and enroll in coverage. You may also enroll your dependents if they are eligible dependents as defined in the Insurer's benefits booklets.

Benefits Provided

The benefits provided under each Benefit Program are more fully described in the Certificate of Insurance/Coverage and other benefits booklets provided by the Insurer.

Your health care benefits are delivered through a network of participating physicians, hospitals, and other providers who have agreed to provide services at a negotiated cost. You have the flexibility to choose providers inside or outside the network each time you need services.

Generally, when you use in-network providers, the Plan pays a higher percentage of covered expenses (after meeting any deductible) and there are no claim forms to complete with the Insurer. When you use out-of-network providers, the Plan pays a lower percentage of covered expenses (after meeting any deductible). You may also pay a higher deductible and out-of-pocket maximum, if applicable, and you may be required to file claim forms for reimbursement. Out-of-network claims will be paid based on the allowed amount, not by the billed charges. Your Certificate of Coverage and other documents provide additional information on how benefits are paid when you access in-network providers and out-of-network providers.

When you enroll in a Plan that uses a network of physicians, you are not required to select a primary care physician to coordinate your care and you do not have to obtain a referral to see a specialist. For a listing of current network health care providers (at no cost to you), contact the Insurer at the telephone number or website shown later in this booklet.

The following type(s) of dental plans or programs of benefits are included under this Plan:

- a DPPO (Dental Preferred Provider Organization)

When you use network providers, the Plan pays the negotiated amount of covered expenses (subject to applicable deductible and coinsurance) to your provider and there are no claim forms to complete. The provider will not balance bill you for the discount provided on the claims. Certain dental options, such as a DMO, may require services to be received only from network providers in order to be covered. You must use network providers in order to receive the maximum benefit payable under the Plan if you are enrolled in this type of plan.

For a listing of current network dental care providers (at no cost to you), contact the Insurer for the dental care plan or program at the telephone number or website shown later in this booklet.

Source of Payments

Benefits for covered services and expenses under the Benefit Program(s) listed above are paid by the Insurer and are guaranteed under the insurance contracts. Any cost-sharing provisions, such as your deductible, co-payment, or coinsurance, are set forth in the materials furnished by the Insurer.

Any required premiums for coverage will be shown in your enrollment materials. Your premiums will be deducted from your pay on a pre-tax basis.

Limitations and Exclusions

The materials for each Benefit Program contain information about limitations on benefits, covered preventive care services, prescription drugs, pre-authorizations required, utilization reviews required, obtaining emergency care, exclusions and expenses not covered, medical tests and procedures covered, any limits or caps on certain coverage, and relative costs for in-network and out-of-network services.

Continuation of Health Care Coverage through COBRA

If your health care coverage under the Plan ends for reasons other than the Employer's termination of all coverage under the Plan, you and/or your eligible dependents may be eligible to elect to continue coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). Health care coverage may continue at your own expense for a specific length of time. See the section entitled "Your HIPAA/COBRA Rights" for additional information. Please note that if your Employer has less than 20 employees, Federal COBRA legislation may not apply to you, but you may instead be eligible for COBRA benefits available through your state. Contact your Insurer for additional information as these provisions vary from state to state.

For More Information

If you have a question about a covered service, or for more information about a specific procedure, coverage of new drugs, tests, or experimental or investigative treatments, you should consult the materials furnished by the Insurer for the coverage in which you are enrolled.

Your Life and Accidental Death & Dismemberment ("AD&D") Coverage

The following Benefit Programs are fully insured and administered by the Insurer(s) listed in Appendix A:

- Group Term Life Insurance
- Voluntary Life Insurance (supplemental and/or dependent life)
- AD&D Insurance

Participation

You must meet all eligibility requirements for coverage in order to become a participant. Enrollment in basic coverage is automatic. Any voluntary options available to you and the associated costs are described in the materials provided by the Insurer. Each year during the annual open enrollment period, you will be given an opportunity to elect or change your voluntary coverage, or confirm that your existing coverage is to be maintained for the following year.

Benefits Provided

The benefits and amounts of coverage provided under each Benefit Program are more fully described in the materials provided to you by the Insurer. Life insurance benefits are paid in the event of the death of a covered participant. AD&D benefits are paid if a covered participant becomes dismembered or seriously injured as the result of a covered accident. You will need to designate a beneficiary to receive benefits in the event of your death.

Source of Payment

Group Term Life Insurance and AD&D benefits are paid by the Insurer and are guaranteed under the applicable insurance contracts.

Both the Company and you share in the cost of your coverage. Any required premiums will be shown on your Election Form. You will be required to make a contribution for the coverage you elect. The amounts of coverage available and the premiums for coverage will be shown on your Election Form when you enroll and will automatically be deducted from your pay.

Plan Limitations and Exclusions

You should refer to the materials provided by the Insurer for information concerning any limitations, waiting periods before coverage begins, maximum benefits payable, when coverage ends, exclusions, age reductions, or reductions for other benefits that may apply.

Coverage Continuation

If your Group Term Life Insurance coverage ends for any reason other than death, you may have a right to continue your insurance under an individual policy. You should consult your Certificate of Insurance for additional information about continuing your coverage as there may be time limits for making this decision once your coverage under the Plan ends.

For More Information

Consult your Certificate of Insurance or benefits booklets for additional questions about your coverage.

Your Disability Benefits

The following Benefit Programs are fully insured and administered by the Insurer(s) listed in Appendix A:

- Voluntary Short-Term Disability (STD) Benefits — Employee paid
- Voluntary Long-Term Disability (LTD) Benefits — Employee paid

Participation

If you wish to elect voluntary STD coverage, you must enroll in coverage after you meet all eligibility requirements. A description of the coverage available is shown in the materials provided by the Insurer. The associated premium costs for voluntary STD coverage will be shown on your Election Form when you first enroll in the Plan.

If you wish to elect voluntary LTD coverage, you must enroll in coverage after satisfying all eligibility requirements for coverage. You must also satisfy any required elimination period defined in the Insurer's materials before LTD benefits are payable. A description of the coverage available is shown in the materials provided by the Insurer. The associated premium costs for voluntary LTD coverage will be shown on your Election Form.

Benefits Provided

Your Certificate of Insurance defines when you are considered disabled. Generally, you are considered disabled when you are unable to perform with reasonable continuity the material duties of your own occupation due to physical disease, injury, or similar disorders.

The STD benefit provided is 60% of your pre-disability pay.

The maximum STD benefit payable is $600 per week. STD benefits continue for a maximum period of 150 days, provided you continue to be disabled.

Benefits for sickness/illness will begin after 31 continuous days of illness. Benefits for an accident or injury will begin after your disability continues for 31 days.

LTD benefits are payable following an elimination period of 181 days. You may elect LTD coverage of up to 60% of your base pay. The options available to you will be shown on your Election Form. The maximum LTD monthly benefit payable is $5,000.

You must be under the direct and continuous care of a licensed physician throughout the period for which disability benefits are paid. In order to continue receiving benefits, you are required to submit evidence, as requested, to support your disability claim. You may also be required to apply for Social Security disability benefits during the fifth month of your disability and, if necessary, appeal a denied claim.

Source of Payment

All disability benefits described above are paid by the Insurer and are guaranteed under the applicable insurance contract(s) or policies.

You may elect voluntary STD coverage; you pay the entire cost of this coverage. The premiums for STD coverage will be automatically deducted from your pay.

Voluntary LTD coverage is available for which you pay the full cost. The premiums for voluntary LTD coverage will be automatically deducted from your pay.

Payment of Benefits

The Insurer is the Claims Administrator and is authorized to handle the day-to-day administrative tasks and pay claims. The Insurer may obtain the services of a licensed physician who will have the full authority and discretion to determine whether an absence is due to the same or related condition.

Offset of Other Benefits

If you become eligible for any disability benefits under state law or disability fund, Workers' Compensation, the Jones Act or any similar laws, state or Federal government income benefits (excluding military pensions), any self-insured, group, or individual pension plan to which the Employer contributes, or if you become entitled to Social Security disability benefits, your disability benefits may be reduced by the amount of benefits you receive, or are entitled to receive, as the result of your disability.

Limitations and Exclusions

No benefits will be payable for any period in which: 1) you engage in any occupation or perform any work for compensation or profit, except approved rehabilitative employment; 2) you are not under the continuous care of a licensed physician; or 3) you are determined not to be disabled.

You should refer to the materials provided by the Insurer for information concerning any additional limitations, waiting periods before coverage begins, maximum benefits payable, when coverage ends, exclusions, taxability of benefits, age reductions, or reductions for other benefits that may apply.

Claims and Appeals

If your claim for disability benefits is denied, you have the right to file an appeal with the Insurer, as described in your Certificate of Insurance and other materials provided by the Insurer. If your claim for benefits is denied, the Insurer will send you written notice of denial which will include the reasons for the decision and other supporting information used to make its decision. Any appeal of a denied claim must be filed within the required time frames specified in the group policy and your Certificate of Insurance.

For More Information

Consult your Certificate of Insurance or benefits booklets for additional questions about your disability coverage.

Your Flexible Spending Account Benefits

Your Health Care Flexible Spending Account

The Health Care Flexible Spending Account offers you a convenient way to pay for eligible, unreimbursed health care expenses using pre-tax dollars. You "fund" your account by directing a portion of your pay to your Flexible Spending Account.

Maximum Annual Amount

The maximum annual benefit amount that you may elect under the Health Care Flexible Spending Account for a calendar year is $2,600.

The Plan Administrator has discretion to change the maximum and/or minimum contributions in subsequent years.

Eligible Medical Expenses

The Health Care Flexible Spending Account will pay only claims incurred during the year that are for eligible "Medical Expenses", as that term is defined in Code Section 213(d), but only to the extent that the expense has not been reimbursed through insurance or otherwise. Expenses may be submitted for you, your spouse, and your "qualified dependents", as such term is defined in Internal Revenue Code Section 152.

The following expenses do not qualify for reimbursement:

- any expense you claim as an itemized deduction on your Federal income tax return;
- premium payments for other health care coverage, including COBRA premiums;
- weight loss programs or dietary supplements;
- hair replacement treatments;
- over-the-counter drugs or medicines unless the purchase was obtained by prescription;
- cosmetic surgery or dentistry procedures, unless related to a congenital abnormality, a personal injury resulting from accident or trauma, or a disfiguring disease; or
- any expense determined to be ineligible as determined by the Plan Administrator.

For a list of eligible expenses, contact the Claims Administrator. Allowable Medical Expenses may also be found in IRS Publication 502 Medical and Dental Expenses or on the IRS Web site at www. irs.gov.

Payment of Health Care Expense Account Claims

The maximum amount available to you for reimbursement will be the lesser of:

- The amount of allowable medical expenses submitted for reimbursement; or
- The total annual Salary Reduction Contribution you elected for the year, less any prior reimbursements.

The Plan will reimburse only those allowable medical expenses which have been incurred by you and/or your dependents that are in excess of any payments or other reimbursements made under any other health care plan. Advance reimbursement will not be made for projected or future expenses.

Continuation Coverage Upon Termination

If your Employer is covered by COBRA and your coverage in the Health Care Flexible Spending Account terminates due to a COBRA qualifying event, you will be given the opportunity to continue (on a self-pay basis) the same coverage you had in effect on the day before the qualifying event, as prescribed by COBRA. However, you may not be eligible for COBRA if you "overspent" your Health Care Flexible Spending Account at the time of the COBRA qualifying event. Your account is overspent if your remaining annual benefit (maximum annual benefit minus the total amount of reimbursable claims submitted before the date of the qualifying event) is less than the maximum COBRA premium that can be charged for the rest of the year. If COBRA is elected, it will be available only for the remainder of the year in which the qualifying event occurs and will cease at the end of that year. Your Health Care Flexible Spending Account coverage cannot be continued for the next year.

Submitting a Claim for Reimbursement

There are a few possible reimbursement methods for FSAs. The methods that are available to you depend on how your FSA is administered. These methods may include, for example, submitting manual or electronic claim forms or allowing you to use an FSA debit card. When you are enrolled in the FSA, your Employer will provide you with more specific information on how your FSA reimburses eligible expenses. Keep in mind that an expense can be reimbursed only after it is incurred. Expenses are incurred at the time the service is received, not when the care or service is billed, charged or paid. In general, prepayment is not permitted. Your FSA can only be used to reimburse eligible expenses. In some circumstances, the Claims Administrator may ask you to provide additional documentation to show that an expense is eligible for reimbursement from your FSA. If you do not provide this information, your claim for reimbursement may be denied.

Claims Submission and Cut-Off

The Plan Administrator will establish and communicate to all participants the cut-off date by which all claims for the year must be submitted. Claims submitted after that date will not be eligible for reimbursement and will be forfeited.

Forfeitures

After processing all claims for a Plan Year, any amount credited to your Expense Account as of the end of that Plan Year will no longer be available for further claims and will be forfeited.

Administrative Information

The following sections contain legal and administrative information you may need to contact the right person for information or help. Although you may not use this information often, it can be helpful if you want to know:

- how to contact the Plan Administrator;
- how to contact the Insurer or Claims Administrators;
- what to do if a benefit claim is denied; and
- your rights under ERISA and other Federal laws such as COBRA.

IMPORTANT: The Employee Retirement Income Security Act (ERISA) is a Federal law. This Summary Plan Description is issued in accordance with ERISA and may not include language or certain mandated coverage required by state insurance laws. State mandated coverage may be addressed separately in the insurance certificates provided by the Insurer.

Plan Sponsor and Administrator

City of Tifton is the Plan Sponsor and the Plan Administrator for this Plan. You may contact the Plan Administrator at the following address and telephone number:

Plan Administrator
City of Tifton
P.O Box 229
Tifton, GA
31793

As set forth in Section 3(16) under ERISA, the Plan Administrator will administer this Plan and will be the "Named Fiduciary" for the Plan. The Plan Administrator will have control of the day-to-day administration of this Plan and will serve without additional remuneration if such individual is an employee of the Employer. The Plan Administrator will have the following duties and authority with respect to the Plan:

- To prepare and file with governmental agencies all reports, returns, and all documents and information required under applicable law;
- To prepare and furnish appropriate information to eligible employees and Plan participants;
- To prescribe uniform procedures to be followed by eligible employees and participants in making elections, filing claims, and other administrative functions in order to properly administer the Plan;
- To receive such information or representations from the Employer, eligible employees, and participants necessary for the proper administration of the Plan and to rely on such information or representations unless the Plan Administrator has actual knowledge that the information or representations are false;
- To properly administer the Plan in accordance with all applicable laws governing fiduciary standards;
- To maintain and preserve appropriate Plan records; and

- To accept all other responsibilities and duties of the administrator of the Plan as specifically set forth in ERISA.

In addition, the Plan Administrator has the discretionary authority to determine eligibility under all provisions of the Plan; correct defects, supply omissions, and reconcile inconsistencies in the Plan; ensure that all benefits are paid according to the Plan; interpret Plan provisions for all participants and beneficiaries; and decide issues of credibility necessary to carry out and operate the Plan.

For fully insured benefits, unless otherwise expressly provided in the insurance policy or contract governing a Benefit Program, the Insurer shall be the Plan Administrator and Named Fiduciary only with respect to the benefits provided through the insurance policy or contract. The Insurer shall be responsible for determining eligibility for and the amount of benefits payable under the Benefit Program, and for prescribing claims procedures to be followed by Participants. The Insurer shall also be responsible for paying claims.

Plan Year

The Plan Year is May 1 through April 30.

Note: An insured benefit may use a policy year that differs from the Calendar Year, with deductible and out-of-pocket expenses based on the policy year. Please refer to the insurance certificate and other materials provided by the Insurer to determine how the policy year impacts your benefits.

Type of Plan

This Plan is a called a "welfare plan", which includes group health plans under ERISA; they help protect you against financial loss in case of sickness or injury.

Identification Numbers

The Employer Identification Number (EIN) and Plan number for the Plan is:

EIN: 58-6000683 PLAN NUMBER: 46

Plan Funding and Type of Administration

Funding and administration of the Plan is as follows.

Type of Administration	The Plan is administered by the Employer through an arrangement with Insurers and third-party (claims) administrators. Insured benefits will be payable solely by the Insurer.
Funding	The Employer and employees both contribute to the Plan. Premiums are paid to the Insurers for fully insured Benefit Programs and benefits will be paid by the Insurer in accordance with the applicable insurance contract/policy.

Funding for this Plan shall consist of an aggregation of the funding for all Benefit Programs. The Employer shall have the right to insure any benefits under this Plan, to establish any fund or trust for the payment of benefits under this Plan, or to do neither and pay benefits under this Plan from its general assets, either as mandated by law or as the Employer deems advisable. In addition, the Employer shall have the right to alter, modify, or terminate any method or methods used to fund the payment of benefits under this Plan, including, but not limited to, any trust or insurance policy.

If any benefit is funded by the purchase of insurance, the benefit shall be payable solely by the Insurer.

Insurers/Claims Administrators

For fully insured Benefit Programs, the Insurer is responsible for administering benefits and paying claims. They may contract with a separate Claims Administrator to process claims. You may contact the Insurer/Claims Administrator directly, using the information listed below.

It is important to understand that if the terms of this SPD conflict with the terms of the insurance certificate regarding substantive rules for an insured Benefit Program (such as benefits and claims procedures), the terms of the insurance certificate will control, unless otherwise required by law.

Dental Benefits

Standard Insurance Company
920 SW Sixth
Ave Portland,
OR 97204
877-490-9991
www.standard.com

Vision Benefits

Standard Insurance Company
920 SW Sixth
Ave Portland,
OR 97204
866-939-3633
www.standard.com

Group Term Life Insurance Benefits

Standard Insurance Company
920 SW Sixth
Ave Portland,
OR 97204
800-628-8600

www.standard.com

STD Benefits

Standard Insurance Company
920 SW Sixth
Ave Portland,
OR 97204
800-368-2859
www.standard.com

LTD Benefits

Standard Insurance Company
920 SW Sixth
Ave Portland,
OR 97204
800-368-1135
www.standard.com

Voluntary/Supplemental Life

Standard Insurance Company
920 SW Sixth
Ave Portland,
OR 97204
888-937-4783
www.standard.com

Agent for Service of Legal Process

For disputes arising under any fully insured Benefit Program, Service of Legal Process may be made upon the Insurer listed above. Service of Legal Process may also be served upon:

City of Tifton
P.O Box 229
Tifton, GA
31793

Service of Legal Process may also be served on the Plan

Administrator. **No Obligation to Continue Employment**

The Plan does not create an obligation for the Employer to continue your employment or interfere with the Employer's right to terminate your employment, with or without cause.

Non-Alienation of Benefits

With the exception of a Qualified Medical Child Support Order, your right to any benefit under this Plan cannot be sold, assigned, transferred, pledged or garnished. The Plan Administrator or, where applicable, the Insurer, has procedures for determining whether an order qualifies

as a QMCSO; participants or beneficiaries may obtain a copy without charge by contacting the Plan Administrator or Insurer.

Severability

If any provision of this Plan is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions shall continue to be fully effective.

Payment of Benefits to Others

The Insurer/Claims Administrator, in its discretion, may authorize any payments due to be paid to the parent or legal guardian of any individual who is either a minor or legally incompetent and unable to handle his or her own affairs.

Expenses

All expenses incurred in connection with the administration of the Plan, are Plan expenses and will be paid from the general assets of the Company.

Fraud

No payments under the Plan will be made if you or a provider of services attempts to perpetrate a fraud upon the Plan with respect to any such claim. The Insurer/Claims Administrator will have the right to make the final determination of whether a fraud has been attempted or committed upon the Plan or if a misrepresentation of fact has been made. The Plan will have the right to recover any amounts, with interest, improperly paid by the Plan by reason of fraud. If you or a covered dependent attempts or commits fraud upon the Plan, your coverage may be terminated and you may be subject to disciplinary action by the Employer, up to and including termination of employment.

Indemnity

To the full extent permitted by law, the Employer will indemnify the Plan Administrator and each other employee who acts in the capacity of an agent, delegate, or representative ("Plan Administration Employee") of the Plan Administrator against any and all losses, liabilities, costs and expenses incurred by the Plan Administration Employee in connection with or arising out of any pending, threatened, or anticipated action, suit or other proceeding in which the Employee may be involved by having been a Plan Administration Employee.

Compliance with State and Federal Mandates

Each Benefit Program will comply to the extent possible with the requirement of all applicable laws, including but not limited to: ERISA, COBRA, USERRA, HIPAA, the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), the Women's Health and Cancer Rights Act of 1998, FMLA, the Mental Health Parity and Addiction Equity Act of 2008, PPACA, HITECH, Michelle's Law (if applicable), and Title I of GINA (prohibiting the use of genetic information to discriminate with respect to health insurance premiums, contributions or other restricted purposes).

Refund of Premium Contributions

For fully insured Benefit Programs, the Plan will comply with DOL guidance regarding refunds (e.g., dividends, demutualization, experience adjustments, and/or medical loss ratio rebates) of insurance premiums. Where any refund is determined to be a plan asset to the extent amounts are attributable to participant contributions, such assets will be: 1) distributed to current plan participants within 90 days of receipt, 2) used to reduce participants' portion of future premiums under the Plan (e.g., premium holiday); or 3) used to enhance future benefits under the Plan. Such determination will be made by the Plan Administrator, acting in its fiduciary capacity, after weighing the costs to the Plan and the competing interest of participants, provided such method is reasonable, fair, and objective.

Nondiscrimination

The Plan is intended to be nondiscriminatory under Code Section 125. Code Section 125 prohibits discrimination in favor of highly compensated individuals with respect to eligibility to participate, highly compensated participants with respect to benefits and contributions and key employees with respect to total Plan contributions. If the Plan Administrator determines, at any time, that the Plan may fail to satisfy these nondiscrimination requirements, the Plan Administrator may take such action as it deems appropriate to comply with the nondiscrimination requirements. This action may include, for example, modifying the elections of highly compensated or key employees without their consent.

No Guarantee of Tax Consequences

Neither the Plan Administrator nor the Employer makes any representation, guarantee or warranty that any amount paid as premiums or distributed as benefits under the Plan will be excludable from your gross income for federal or state income tax purposes (or that any other state or federal tax treatment will apply or be available to you). It is your responsibility to determine whether payments are excludable from your gross income for federal and state income tax purposes.

Future of the Plan

The Employer expects that the Plan will continue indefinitely. However, the Employer has the sole right to amend, modify, suspend, or terminate all or part of the Plan at any time.

The Employer may also change the level of benefits provided under the Plan at any time. If a change is made, benefits for claims incurred after the date the change takes effect will be paid according to the revised Plan provisions. In other words, once a change is made, there are no rights to benefits based on earlier Plan provisions.

Claims Procedures/Coordination of Benefits

This section describes what you must do to file or appeal a claim for services. It also describes how benefits under this Plan are coordinated with other benefits to which you or a covered dependent might be entitled.

Claims and Appeals

For fully insured Benefit Programs, the claims procedures, including issues related to payment, preauthorization approval, or utilization review, as well as the time frames for submitting claims, are set forth in the insurance certificates.

If your claim is denied and you disagree and want to pursue the matter, you must file a First Level Appeal with the respective Insurer. A rescission of coverage is also considered an adverse benefit determination that triggers your right to file an appeal. You or your authorized representative may appeal a denied claim within the time frame provided in the insurance certificates for that Benefit Program. Different time frames apply to healthcare claims and disability-related claims. You will have the right to submit for review, written comments, documents, records, and other information related to the claim; and to request, free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claim.

The Insurer, acting on behalf of the Plan, has full and exclusive authority and discretion to construe and interpret the provisions of the Program, to determine questions of coverage, and entitlement to and termination of benefits, and to make factual findings. If the Insurer denies your claim (in whole or in part) during a First Level Appeal, you may file a Second Level Appeal. If after such review, the Insurer continues to deny the claim in full or in part, you will be notified of the decision in writing.

The Insurer's decision will include specific reasons for the decision, written in a manner calculated to be easily understood, with specific references to the Benefit Program's provision or provisions, including any internal rules, guidelines, protocol, or other similar criterion relied upon, on which the appeal decision is based. It will also include a statement of your right to access and receive copies of all documents, records, and other information relevant to your appeal. You will also be provided a statement advising that you are entitled to bring civil action in Federal court under Section 502(a) of ERISA.

Exhaustion Required

The decision of the Insurer for fully insured Benefit Programs shall be final and conclusive on all persons claiming benefits under the Benefit Program, subject to applicable law. No other actions may be brought by any person until an appeal for denied benefits has been brought and been denied (or deemed denied) as described above under the respective claims procedure. You must exhaust all remedies available to you before bringing legal action. You cannot take any other steps unless and until you have exhausted all appeals. For example, if your claim is denied and you do not use the appeals procedures, the denial of your claim will be conclusive and cannot be challenged, even in court.

Non-Duplication of Benefits / Coordination of Benefits

If you (or an eligible dependent) are covered by another employer's plan, the two plans work together to avoid duplicating payments. This is called non-duplication or coordination of benefits. The Insurer is responsible for ensuring that eligible expenses are coordinated with benefits from:

- other employers' plans;
- certain government plans; and
- motor vehicle plans when required by law.

The Insurer may request information about other coverage you may have. You are required to provide this information to ensure that claims are properly paid.

Subrogation and Reimbursement

If you or your dependent receives benefits in excess of the amount payable under the Plan, the Insurer has a right to subrogation and reimbursement. Subrogation applies when the Insurer has paid benefits for a sickness or injury for which a third party is considered responsible (e.g., an insurance carrier if you are involved in an auto accident).

The Plan Administrator has delegated all subrogation rights and third party recovery rights to the Insurer of each fully insured Benefit Program. The Insurer shall undertake reasonable steps to identify claims in which the Plan has a subrogation interest and shall manage subrogation cases on behalf of the Plan. You are required to cooperate with the Insurer to facilitate enforcement of its rights and interests.

These provisions shall not apply where subrogation is specifically prohibited by enforceable law.

Your Rights under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants will be entitled to the following.

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series), if applicable, and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse, or dependents if there is a loss of 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.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare 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.

Under ERISA, there are steps you can take to enforce the previously mentioned rights. For instance, if you request a copy of Plan documents (i.e., Summary Plan Descriptions and Summary of Material Modifications) or the latest annual report from the Plan and do not receive it within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If, after you exhaust your appeals, you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. Such suit must be filed

within 180 days from the date of an adverse appeal determination notice. In addition, if you disagree with the Plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in 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 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 (for example, if the court finds your claim is frivolous), the court may order you to pay these costs and fees.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, 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 also may obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration at 1-866-444-3272.

Your HIPAA Rights

Health Insurance Portability and Accountability Act (HIPAA)

Title II of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations at 45 CFR Parts 160 through 164 (HIPAA) contain provisions governing the use and disclosure of Protected Health Information (PHI) by group health plans, and provide privacy rights to participants in those plans. These rules are called the HIPAA Privacy Rules.

You will receive a "Notice of Privacy Practices" from the Administrator(s) and/or Insurer(s) that contains information about how your individually identifiable health information is protected under the HIPAA Privacy Rules and who you should contact with questions or concerns.

The HIPAA Privacy Rules apply to group health plans. These plans are commonly referred to as "HIPAA Plans" and are administered to comply with the applicable provisions of HIPAA. PHI is individually identifiable information created or received by HIPAA Plans that relates to an individual's physical or mental health or condition, the provision of health care to an individual, or payment for the provision of health care to an individual. Typically, the information identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper or oral. When PHI is in electronic form it is called "ePHI."

The HIPAA Plans may disclose PHI to the Plan Sponsor only as permitted under the terms of the Plan, or as otherwise required or permitted by HIPAA. The Plan Sponsor agrees to use and disclose PHI only as permitted or required by the HIPAA Privacy Rules and the terms of the Plan.

The HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose enrollment and disenrollment information to the Plan Sponsor. Also, the HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the information for the purposes of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending or terminating the Plan. "Summary Health Information" means information that summarizes the claims history, claims expenses or types of claims experienced by individuals covered under the HIPAA Plans and has almost all individually identifying information removed. The HIPAA Plans may also disclose PHI to the Plan Sponsor pursuant to a signed authorization that meets the requirements of the HIPAA Privacy Rules. Other than these disclosures, the Plan Sponsor will not create or receive PHI from the HIPAA Plans.

Your COBRA Continuation Coverage Rights

Continuing Health Care Coverage through COBRA

This section provides an overview of COBRA continuation coverage. The coverage described may change as permitted or required by applicable law. When you first enroll in coverage, you will receive from the Plan Administrator/COBRA Administrator your initial COBRA notice. This notice and subsequent notices you receive will contain current requirements applicable for you to continue coverage.

The length of COBRA continuation coverage (COBRA coverage) depends on the reason that coverage ends, called the "qualifying event." These events and the applicable COBRA continuation period are described below.

If you and/or your eligible dependent(s) choose COBRA coverage, the Employer is required to offer the same medical and prescription drug coverage that is offered to similarly situated employees. Proof of insurability is not required to elect COBRA coverage. In other words, you and your covered dependents may continue the same healthcare coverage you had under the Plan before the COBRA qualifying event.

If you have a new child during the COBRA continuation period by birth, adoption, or placement for adoption, your new child is considered a qualified beneficiary. Your new child is entitled to receive coverage upon his or her date of birth, adoption, or placement for adoption, provided you enroll the child within 30 days of the child's birth/adoption/placement for adoption. If you do not enroll the child under your coverage within 30 days, you will have to wait until the next open enrollment period to enroll your child.

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

For more information about the Marketplace, visit

www.HealthCare.gov. **COBRA Qualifying Events and Length of**

Coverage

Each person enrolled in benefits will have the right to elect to continue healthcare benefits upon the occurrence of a qualifying event that would otherwise result in such person losing healthcare benefits. Qualifying events and the length of COBRA continuation are as follows:

18-Month Continuation

Healthcare coverage for you and your eligible dependent(s) may continue for 18 months after the date of the qualifying event if your:

employment ends for any reason other than gross

misconduct; or hours of employment are reduced.

If you or your eligible dependent is disabled at the time your employment ends or your hours are reduced, the disabled person may receive an extra 11 months of COBRA coverage in addition to

the 18-month continuation period (for a total of 29 months of coverage from the date of the qualifying event). If the individual entitled to the disability extension has non-disabled family members who have COBRA coverage due to the same qualifying event, those non-disabled family members will also be entitled to the 11-month extension, including any child born or placed for adoption within the first 60 days of COBRA coverage.

The 11-month extension is available to any COBRA participant who meets all of the following requirements:

- he or she becomes disabled before or within the first 60 days of the initial 18-month coverage period (including a child born or placed for adoption with you); and
- he or she notifies the Plan Administrator (or its designated COBRA Administrator) within 60 days of the date on the Social Security Administration determination letter, and provides a copy of the disability determination; and
- he or she notifies the Plan Administrator (or its designated COBRA Administrator) before the initial 18-month COBRA coverage period ends.

You must also notify the Plan Administrator (or its designated COBRA Administrator) within 30 days of the date Social Security Administration determines that you or your dependent is no longer disabled.

36-Month Continuation

Coverage for your eligible dependent(s) may continue for up to 36 months if coverage is lost due to your:

- death;
- divorce or legal separation;
- eligibility for Medicare coverage; or
- dependent child's loss of eligible dependent status under this Plan

Note: If any of these events (other than Medicare entitlement) occur while your dependents are covered under COBRA (because of an 18-month or 18-month plus 11 month extension qualifying event), coverage for the second qualifying event may continue for up to a total of 36 months from the date of the first COBRA qualifying event. In no case, however, will COBRA coverage be continued for more than 36 months in total.

If you become eligible for Medicare before a reduction in hours or your employment terminates, coverage for your dependents may be continued for up to 18 months from the date of your reduction in hours or termination of employment, or for up to 36 months from the date you became covered by Medicare, whichever is longer.

COBRA Notifications

If you or your covered dependents lose coverage under the Plan because your employment status changes, you become entitled to Medicare, or you die, the Plan Administrator (or its designated COBRA administrator) will automatically provide you or your dependents with information about COBRA continuation coverage, including what actions you must take by specific deadlines.

If your covered dependent loses coverage as a result of your divorce, legal separation, or a dependent child's loss of eligibility under the Plan, you or your dependent must notify the Employer within 60 days of the qualifying event. The Plan Administrator (or its designated COBRA administrator) will automatically send you or your dependent, as applicable, COBRA enrollment information. If you or your dependent fails to provide notification of the event within 60 days, you or your dependent forfeits all continuation of coverage rights under COBRA. To continue COBRA coverage, you and/or your eligible dependents must elect and pay the required cost for COBRA coverage by completing and returning your COBRA enrollment form.

NOTE: If you have a new child during the COBRA continuation period by birth, adoption or placement for adoption, your new child is entitled to the status of a qualified beneficiary. As such, your new child is entitled to receive coverage upon his or her date of birth, date of adoption or date placement for adoption is made and you become legally obligated to provide support for the child, provided you enroll the child within thirty (30) days of the child's birth/adoption/placement.

Cost of COBRA Coverage

You or your eligible dependent pay the full cost for healthcare coverage under COBRA, plus any required administrative fee up to two percent, or up to 102 percent of the full premium cost, except in the case of an 11-month disability extension where you may be required to pay up to 150 percent of the full premium cost for coverage.

COBRA Continuation Coverage Payments

Each qualified beneficiary may make an independent COBRA coverage election. You elect coverage by completing and returning your COBRA enrollment form as instructed in your enrollment materials within 60 days of the date you receive information about your COBRA rights or, if later, the date of your qualifying event.

The first COBRA premium payment is due no later than 45 days from the date COBRA coverage is elected. Although COBRA coverage is retroactive to the date of the initial qualifying event, no benefits will be paid until the full premium payment is received. Each month's premium is due prior to the first day of the month of coverage. You or your dependent is responsible for making timely payments.

If you or your dependent fails to make the first payment within 45 days of the COBRA election, or subsequent payments within 30 days of the due date (the grace period), COBRA coverage will be canceled permanently, retroactive to the last date for which premiums were paid. COBRA coverage cannot be reinstated once it is terminated.

COBRA premium payments that are returned by the bank for insufficient funds will result in termination of your COBRA coverage if a replacement payment in the form of a cashier's check, certified check, or money order is not made within the grace period.

COBRA premium payments must be mailed to the address indicated on your premium notice. Even if you do not receive your premium notice, it is your responsibility to contact the COBRA administrator. Your COBRA coverage will end if payment is not made by the due date on your notice. It is your responsibility to ensure that your current address is on file.

You may be eligible for state or local assistance to pay the COBRA premium. For more information, contact your local Medicaid office or the office of your state insurance commissioner.

How Benefit Extensions Impact COBRA

If you have a qualifying event that could cause you to lose your coverage, the length of any benefit extension period is generally considered part of your COBRA continuation coverage period and runs concurrently with your COBRA coverage.

If you take a leave under the Family and Medical Leave Act (FMLA), COBRA

begins; at the end of the leave if you do not return after the leave; or on the date of termination if you decide to terminate your employment during the leave.

When COBRA Coverage Ends

COBRA coverage for a covered individual will end when any of the following occur:

- The premium for COBRA coverage is not paid on a timely basis (monthly payments must be postmarked within the 30-day grace period, your initial payment must be postmarked within 45 days of your initial election).
- The maximum period of COBRA coverage, as it applies to the qualifying event, expires.
- The individual becomes covered under any other group medical plan.
- The individual becomes entitled to Medicare.
- The Employer terminates its group health plan coverage for all employees.
- Social Security determines that an individual is no longer disabled during the 11-month extension period.

Definitions

COBRA

The Consolidated Omnibus Budget Reconciliation Act. This Federal law allows a continuation of healthcare coverage in certain circumstances for Employers with 20 or more employees. Small Employers may be subject to individual state COBRA provisions.

Dependent

The definition of a dependent is defined in the insurance certificate and other materials provided by the Insurer. Under the PPACA, your dependent for health insurance coverage includes your child under age 26, regardless of financial dependency, residency with you, marital status, or student status.

Certain states may impose a different definition of dependent that extends coverage beyond age 26. Your employer also may elect a more generous definition of dependent or apply the above definition to other Benefit Programs. For questions regarding dependent eligibility, contact the Plan Administrator.

Employee

A person who is a fulltime employee and who is regularly scheduled to work for the Employer in an employer-employee relationship. The definition of an eligible employee is defined in the Plan Overview.

Election Form

The form used by employees to elect to participate in a Benefit Program and to authorize payment of premiums for such Benefit Program, where applicable.

ERISA

The Employee Retirement Income Security Act of 1974, as amended, a Federal law that governs group benefit plans.

Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) is a Federal law that provides for an unpaid leave of absence for up to 12 weeks per year for:

- the birth or adoption of a child or placement of a foster child in a participant's home;
- the care of a child, spouse or parent (not including parents-in-law), as defined by Federal law, who has a serious health condition;
- a participant's own serious health condition; or
- any qualifying exigency arising from an employee's spouse, son, daughter, or parent being a member of the military on "covered active duty". Additional military caregiver leave is available to care for a covered service member with a serious injury or illness who is the spouse, son, daughter, parent, or next of kin to the employee.

Generally, you are eligible for coverage under FMLA if you have worked for your Employer for at least one year; you have worked at least 1,250 hours during the previous 12 months; your Employer has at least 50 employees within 75 miles of your worksite; and you continue to pay any required premium during your leave as determined by the Employer. Various states also have enacted similar legislation for their residents. Covered employers must comply with the Federal or state provision that provides the greater benefit to their employees. If you have

questions regarding your eligibility for FMLA coverage or your state's family medical leave provisions, if applicable, contact your Employer.

GINA

The Genetic Information Nondiscrimination Act of 2008, as amended.

HIPAA

Health Insurance Portability and Accountability Act of 1996, as amended.

HITECH

The Health Information Technology for Economic and Clinical Health Act, as amended.

Insurer

Any insurance company that fully insures (or partially insures) any benefit provided by this Plan or any Benefit Program.

Leased Employee

Leased employee as defined in the Internal Revenue Code, section 414(n), as

amended. **Medicare**

The program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

NMHPA

The Newborns' and Mother's Health Protection Act of 1996, as amended. Group health plans and health insurance issuers generally may not, under Federal law, 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 cesarean 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 issuers may not, under Federal law, 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).

Participant

An eligible employee who elects to participate in the Plan by completing the necessary Election Form on a timely basis, as provided by the Plan Administrator.

PPACA

The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010.

Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN)

Any court order that: 1) provides for child support with respect to the employee's child or directs the employee to provide coverage under a health benefit plan under a state domestic relations law, or 2) enforces a law relating to medical child support described in the Social Security Act, Section 1908, with respect to a group health plan. A QMCSO or an NMSN also may be issued through an administrative process established under state law. A participant must notify the Plan Administrator if he or she is subject to a QMCSO or an NMSN.

USERRA

The Uniformed Services Employment and Reemployment Rights Act of 1994; a Federal law covering the rights of participants who have a qualified uniformed services leave.

WHCRA

The Women's Health and Cancer Rights Act of 1998, as amended. Your medical coverage under the Plan includes coverage for a medically necessary mastectomy and patient-elected reconstruction after the mastectomy. Specifically, for you or your covered dependent who is receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for: 1) All stages of reconstruction of the breast on which the mastectomy was performed; 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; 3) Prostheses; and 4) Treatment of physical complications at all stages of mastectomy, including lymphedema.

Adoption of the Plan

The City of Tifton, as stated herein, is hereby adopted as of 05/01/2017. This document constitutes the basis for administration of the Plan.

IN WITNESS WHEREOF, the parties have caused this document to be executed on this

___________ day of ________________________________ , 201 .

BY: ______________________________

TITLE: ______________________________

APPENDIX A

BENEFIT PROGRAM	NAME OF INSURER/ CLAIMS ADMINISTRATOR	POLICY OR CONTRACT NUMBER(S)	START OF POLICY YEAR OR EFFECTIVE DATE OF COVERAGE	ELIGIBILITY	CLAIMS PROCEDURE & BENEFITS
GROUP DENTAL INSURANCE	STANDARD INSURANCE COMPANY INSURER/CLAIMS ADMINISTRATOR	752789	May **1**	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
GROUP VISION BENEFITS	STANDARD INSURANCE COMPANY INSURER/CLAIMS ADMINISTRATOR	752789	May 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
GROUP TERM LIFE INSURANCE BENEFITS	STANDARD INSURANCE COMPANY INSURER/CLAIMS ADMINISTRATOR	752789	May 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance *and* other benefit materials provided by Insurer.
SHORT-TERM DISABILITY BENEFITS	STANDARD INSURANCE COMPANY INSURER/CLAIMS ADMINISTRATOR	752789	May 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
LONG-TERM DISABILITY BENEFITS	STANDARD INSURANCE COMPANY INSURER/CLAIMS ADMINISTRATOR	752789	May 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.

BENEFIT PROGRAM	NAME OF INSURER/ CLAIMS ADMINISTRATOR	POLICY OR CONTRACT NUMBER(S)	START OF POLICY YEAR OR EFFECTIVE DATE OF COVERAGE	ELIGIBILITY	CLAIMS PROCEDURE & BENEFITS
VOLUNTARY/SUPPLE MENTAL LIFE	STANDARD INSURANCE COMPANY INSURER/CLAIMS ADMINISTRATOR	752789	May 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.