

Note: A Salary Reduction Enrollment Form referred to in the document is not needed. Unless otherwise communicated in writing to payroll, all eligible deductions will automatically fall into the 125 plan for pre-tax benefits.

**COFFEE COUNTY BOARD OF EDUCATION
PREMIUM CONVERSION AND H S A CONTRIBUTION PLAN
SUMMARY PLAN DESCRIPTION**

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Article I

INTRODUCTION TO YOUR PLAN

COFFEE COUNTY BOARD OF EDUCATION offers a combined “Premium Conversion Plan” and “Health Savings Contribution Plan” as part of your employee benefits program. This Plan is intended to qualify under Section 125 of the Internal Revenue Code (IRC). Under IRC Section 125, you can take advantage of the tax-free benefits (premiums & H S A Contributions) offered under the Plan, as described in this summary.

Your Plan is a “Salary (or wage) Reduction” plan. This means that you pay your share or all of the cost of your benefits by electing to have your compensation reduced. In some situations, both you and the Employer may contribute to pay for some of these benefits and some may be Employee only contributions. The Employer pays its portion out of its general assets. To pay your share, you must file a Salary Reduction Enrollment Form “Enrollment Form” which contains a “Salary (or wage) Reduction Agreement” with the Plan Administrator. The Employer will

deduct from your paycheck, and in accordance with your Agreement, an amount sufficient to pay for your portion or all of your benefits.

Any money you contribute to pay for your benefits is not subject to Federal income, Social Security or Unemployment taxation. Therefore, your benefit costs are quite low, and in some cases, can even result in a net increase in spendable income to you, after paying for your benefits.

This Summary Plan Description is a brief description of the Plan and your rights, benefits and obligations under the Plan. This Summary Plan Description is not meant to interpret, extend or change any provision contained in the main Plan Document. The provisions of COFFEE COUNTY BOARD OF EDUCATION Premium Conversion and Health Savings Contribution Plan can only be accurately understood by reading the written Plan Document. This Document is on file with the Employer and may be read by you or your dependents or your legal representative by contacting the Benefits Coordinator, who is responsible for making the Plan Document available to you at any reasonable time, upon request.

Article II

You may need the following information if you have any questions about your Plan.

1. GENERAL INFORMATION

The name of this Plan is **COFFEE COUNTY BOARD OF EDUCATION Premium Conversion and Health Savings Contribution Plan.**

The provisions of your Plan became effective on **January 1, 2016.**

Your Plan shall be governed by the Laws of the **State of Tennessee.**

2. EMPLOYER INFORMATION

The name, address and tax identification number of the Employer are:

COFFEE COUNTY BOARD OF EDUCATION

1343 McArthur Street, Manchester, TN 37355

EI#: 62-6000543

3. PLAN ADMINISTRATOR INFORMATION

The telephone & fax number of your Plan Administrator are:

Phone: 931-723-5150 Fax: 931-723-5153

Your Plan Administrator is responsible for the administration of your Plan. Should you need to see any records or have any questions regarding the Plan, contact the Plan Administrator.

4. BENEFITS COORDINATOR

COFFEE COUNTY BOARD OF EDUCATION has been named as the Plan's Benefits Coordinator. If you need additional information about the plan or the benefits offered, the Benefits Coordinator will be able to assist you.

5. LEGAL REPRESENTATIVE

Service of legal process may be made upon the Plan Administrator, who is your Employer.

6. Plan Number 105

Article III

PARTICIPATION IN YOUR PLAN

All employees who meet the participation requirements are eligible to participate in this Plan. To qualify as a participant under this Plan, you must meet the following requirements:

- You must be a full time employee working 25 or more hours per week
- For H S A benefits, you must be enrolled in High Deductible Health Plan

Employees who fall into the following groups are excluded from participating in the Plan:

- Part-Time Employees who work less than **25 hours per week**
- Employees who are non-resident aliens and receive no earned income from the employer that constitutes income from sources within the United States.

You're not eligible for the Health Savings Contribution Benefit, if you are

- Covered by another health insurance plan, such as a spouse's plan, that is not a qualified HDHP
- Claimed as a dependent on another person's tax return
- Enrolled in Medicare benefits (if you are enrolled in Medicare and already have an HSA, you can continue to use the money in your account, but you cannot make new contributions to the account or open a new HSA)

If you become eligible under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for coverage by an Accident or Health Benefit available under the Plan you shall be allowed to participate in the Plan, so long as you comply with the provisions set out in HIPAA. See your Plan Administrator for details.

Your Entry Date, the date you may actually join the Plan, is on the first day of the month following, or coincident with, the date you meet all of the above eligibility requirements.

ENROLLMENT FORM

1. You will be required to file a Salary Reduction Enrollment Form (Enrollment Form) before your Entry Date (and before the start of each Plan Year, thereafter). The Enrollment Form is an agreement between you and your Employer, where your Employer lists the benefits offered for the Plan Year. It will also specify the amount you have agreed to contribute toward the cost of these benefits, in the Salary (or Wage) Reduction Agreement part of the form. This is an agreement between you and your Employer, which states that you agree to have your compensation reduced by the amount necessary to pay for the benefits. Any money you contribute to this Plan will not be subject to Federal income taxation.

If you do not file a new Salary Reduction Enrollment Form with the Plan Administrator before the start of the new Plan Year, it will be assumed that you selected the same benefits as in the previous Plan Year, and your compensation will be reduced accordingly by the Employer. If you do not want to participate in your Plan for the new Plan Year, you must inform the Plan Administrator in writing of your wish.

LIMITATIONS ON CONTRIBUTIONS

The Maximum Contribution you can make to the Premium Conversion Plan is an amount equal to the total cost of purchasing the most expensive premium-type benefit available from each Benefit Category.

Health Savings Contributions are made into the employee's account by the individual and/or the individual's employer and are limited to a maximum amount each year. The contributions are non-taxable and invested over time to be used to pay for qualified medical expenses, which include most medical care such as dental, vision and over-the-counter drugs. H S A contributions are limited to IRS inflation-adjusted criteria determined by the IRS on an annual basis.

"Benefit Category" refers to each category of benefits such as health insurance, group term life insurance, and health savings account contributions. These are **examples only**, the actual benefits offered under this Plan are limited to premium and health savings contributions.

CHANGE IN ELECTIONS/CHANGE IN STATUS

The laws governing Premium Conversion Plans generally do not allow you to change the terms of your Enrollment Form during a Plan Year. There are, however, a few exceptions to this rule. You may change your benefit elections if there is a change in your status. Such a change might include your marriage or divorce; your spouse commencing or terminating employment; a change in work status (such as from full-time to part-time or vice versa); you or your spouse taking an unpaid leave of absence from work; a significant change in health coverage due to your spouse's employment; the birth, adoption or death of a child or other dependent of yours; a child reaching the age of majority or some other circumstance where that person is no longer considered a dependent. This list is only a partial list of what might be considered a change in status. It is up to the Plan Administrator to determine what is and is not a change in status, and the judgment of the Plan Administrator must be made in reliance with the laws governing Premium Conversion Plans.

Health Savings Accounts allow election changes to be made prospectively on a monthly basis, with contributions non-taxable to the Employee under the Plan.

Also, you (or your estate) will not be required to make further contributions to the Plan once you have died, retired, terminated employment, or have a change in job status so that you are no longer eligible to participate under this Plan.

If you do have a change in status or Health Savings Account and wish to change your benefit elections, you must notify the Plan Administrator. If the Plan Administrator determines that your change in status is a permitted change under the law, and that the election change is consistent

with your change in status, the Plan Administrator will allow you to file a form, with new benefit choices that reflect your change in status.

Note that the new premium benefit elections can start only after your change in status has taken place and the new form has been filed. For example, assume that you are going to be married. You could request a change in your benefits to add health coverage for your spouse to be effective on your wedding day. However, making other unrelated changes or changes that are effective before your wedding day would not be approved.

Also, you may be required to increase your premium contribution if the Plan's cost for a particular benefit should increase during the Plan Year. If, for example, premiums for health insurance offered under the Plan are raised during the year, you will have the option of either paying your share of the increased premiums or selecting another health insurance option offered under the Plan.

ENDING PLAN PARTICIPATION AND LEAVES OF ABSENCE

Ending Plan Participation

In general, when you terminate employment, your participation in the Plan is suspended until the last day of the Plan Year. If you should be rehired during the same Plan Year as the year you terminated, the elections you made before your termination will resume.

Continuing Plan Participation Under COBRA and FMLA

Special rules, called COBRA provisions, apply to certain health or medical plans. If you terminate employment or have another "qualifying event" that affects your health plan, your Benefits Coordinator will give you an explanation of COBRA and your rights to continued coverage, if COBRA applies to your plan. If COBRA does not apply to your Plan, state continuation may be applicable.

Health Savings Contributions may be continued by the participant after termination (up to the annual maximum) as the H S A belongs to the employee and remains with the employee.

The Family and Medical Leave Act ('the FMLA') requires employers with 50 or more employees to provide unpaid leave for eligible employees at the time of the birth or adoption of a child or at the time of a serious health condition affecting the employee or a family member.

Article IV

PAYING FOR BENEFITS UNDER YOUR PLAN

INTRODUCTION

There are two basic types of benefits offered under your plan: **Premium and Health Savings Contribution benefits.**

Premium benefits are insurance benefits, such as health, dental, vision, life and disability insurance that require premium payment for on-going coverage. Not all premium benefits may be allowed under the plan, therefore you should contact your human resources manager for current information regarding premium benefits that may be paid pre-tax through payroll deductions.

Health Savings Contribution benefits are benefits for participants who are covered under high-deductible health plans (HDHPs) to save for medical expenses that HDHPs do not cover. Contributions are made into the account by the individual and/or the individual's employer and are limited to a maximum amount each year. The contributions are invested over time and can be used to pay for qualified medical expenses, which include most medical care such as dental, vision and over-the-counter drugs. H S A contributions are limited to IRS inflation-adjusted criteria determined by the IRS on an annual basis.

PAYMENT OF PLAN EXPENSES

The cost of the plan includes administrative expenses and the amount paid to provide benefits such as premium payments to insurance companies. The amount needed to provide your benefits depends on the selections you made on the Enrollment Form. You and your Employer may share in the cost of your benefits under your Plan or the full cost may be required to be paid by you. If the Employer contributes to the cost of your benefits, the Employer pays its portion from the general corporate assets and you pay your portion through salary (or wage) reductions.

Article V

ADMINISTRATION OF YOUR PLAN

The Plan Administrator is responsible for the administration of your Premium Conversion and Health Savings Contribution Plan. The duties of the Plan Administrator include determining who is eligible to participate, interpreting laws and regulations and how they apply to your Plan and whether or not certain expenses should be allowed under the Plan.

When you are ready to enter the Plan, you must file an Enrollment Form and Salary (or Wage) Reduction Agreement with the Plan Administrator. After becoming a participant in the Plan, file all change requests with the Plan Administrator. The Plan Administrator will determine, in accordance with the various laws that apply to the Plan, whether or not to grant your requests.

The Plan Administrator can demand any documents or evidence deemed necessary to properly administer your Plan. If the Plan Administrator feels that you have submitted insufficient data to make a determination, or that the request made is not allowed under the Plan, the Plan Administrator can deny your request. After the request has been denied, you will be allowed an opportunity to appeal. The Plan Administrator must furnish you in writing the reasons for the denial of your claim for benefits. The written denial must be provided to you within 30 days of the date the claim for benefits was denied by the Plan Administrator. The written denial must refer to the Plan provision, or section of the Internal Revenue Code upon which the Plan Administrator relied in making such denial. The denial may include a request for any additional data or material needed to properly complete the claim and explain why such data or material is necessary, and explain the Plan's claim review procedures. If requested in writing, and within 180 days of the claim denial, the Plan Administrator is required to give you a full and fair review of the Plan Administrator's decision, and within 60 days of the request for review of the denied claim, the Plan Administrator shall notify you in writing of his final decision on the reviewed claim.

With respect to the denial of any claim for benefits from an insurance company or other third-party benefit provider, paid for as a premium-type Benefit under the Plan, the review procedures of the insurance company or other third-party benefit provider shall apply.

If your request was denied because the Plan Administrator felt your request is not covered under the Plan, you will be given the chance to show why it should have been allowed under the Plan. If the Plan Administrator rejects your reasons, you will not be able to appeal again.

You may, however, feel that you were treated unfairly. The Employee Retirement Income Security Act of 1974 (ERISA) provides all plan participants with certain rights. If you feel the Plan Administrator violated these rights, you may be able to take legal action in a court of law. Generally, this type of action can be taken only if you can prove that the Plan Administrator did not act in accordance with the terms of your Plan, or that the Plan Administrator acted in bad faith when making its decision.

In addition to interpreting the plan and making sure that benefits are properly paid, the Plan Administrator also keeps all the records of the Plan. Should you need a copy of anything filed with the Plan Administrator, contact the Plan Administrator directly.

Article VI

BENEFITS UNDER YOUR PLAN

Your Premium Conversion and Health Savings Contribution Plan offers several benefit options. It is very important that you make benefit choices that fit your benefit needs. You should not, for example, choose a benefit just because it is the least expensive if that benefit will not fit your needs. When making your decision as to what benefits are best for you, you should consider factors such as whether you have benefits from another source (such as coverage under a similar plan by your spouse's employer), the number of dependents you are covering and the amount you can afford to spend. Your Benefits Coordinator will be glad to assist you in making the best benefit choices for your particular situation.

Article VII

STATEMENT OF ERISA RIGHTS

As a participant in **COFFEE COUNTY BOARD OF EDUCATION Premium Conversion and Health Savings Contributions 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 shall be entitled to:

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the Department of Labor, such as detailed annual reports and plan descriptions.

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 participants and beneficiaries. No one, including your employer, 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. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file a suit in 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 you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous. If you have any questions about this statement or about your rights under ERISA, 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.

Article VIII

DEFINITIONS

“Accident or Accidental”, means accidental bodily injury which is sustained independently of disease, illness or bodily infirmity.

“Attachments” means any documentation identified as attached to this document which together with this document constitute the plan document.

“Benefits” mean cash and the various qualified benefits under Section 125(f) of the Code sponsored by the Employer and made available by the Employer through the Plan, including, but not limited to, health insurance, group term life insurance and disability insurance.

“Benefits Accounts” mean the accounts established by the Plan Administrator under the Plan for each Participant's Benefits for purposes of administering the Plan.

“Benefits Enrollment Form” means the form or forms, including a Salary Reduction Agreement, evidencing an Eligible Employee's selections from among the various Benefits and the amount to be contributed towards various Benefits for a Plan Year or portion of a Plan Year.

“Cafeteria Plan” means the plan, established by the Company, through which choices of and pre-tax payment for benefits are made in accordance with Code § 125.

“Certificate of Coverage”, means a document that confirms that an insured party has purchased insurance coverage. It's typically requested by the clients of the insured. The insured is the person or entity who has bought the insurance from an agent of the insurance company. It is issued to the insured's client by the insurance company; the document is proof that the insured party has properly been insured under a particular insurance policy. It includes the name of the insurance company and the name of the insured. Also, it provides the policy number, policy coverage period, the insured's address, and coverage types.

“Claimant”, means a person who has filed a claim for benefits under the Policy, as an Insured or as the beneficiary of the insured.

“COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

“Code” means the Internal Revenue Code of 1986, as amended from time to time.

“Company” means COFFEE COUNTY BOARD OF EDUCATION or any successor thereto.

“Contributory”, means the employee pays all or a portion of the premium due for coverage.

“Co-insurance”, means your share of the costs of service, calculated as a percent of the allowed amount for the service. For example, if the plan’s allowed amount for an overnight hospital stay is \$100, your co-insurance payment of 20% would be \$20. This may change if you haven’t met your deductible.

“Co-payments”, means a fixed dollar amount (for example, \$15) you pay for covered health care, usually when you receive the service.

“Covered Person”, means any Eligible Employee covered under the Plan, and any individual who is eligible for and covered under the Plan due to the individual’s relationship to an Eligible Employee (such as the Employee’s spouse, child, or other eligible family member). If a benefit requires enrollment, only an individual who has enrolled is considered a Covered Person with respect to that benefit.

“Compensation” means all the earned income, salary, wages and other earnings paid by the Employer to a Participant during a Plan Year, including any amounts contributed by the Employer pursuant to a salary reduction agreement which are not includable in gross income under Sections 125, 402(g)(3), 402(h), 403(b) or 457(b) of the Code.

“Deductible”, means the amount you are required to pay for covered health services before benefits are paid by the provider under the Policy

“Dependent” means an individual who is a dependent, within the meaning of Section 152(a) of the Code, of a Participant or a former Participant in the Plan. Effective March 30, 2010, PPACA added a second type of dependent child to Internal Revenue Code Section 105 that may now be covered under a group health plan on the same non-taxable basis — any son, daughter, stepson, stepdaughter, eligible foster child, or adopted child of the employee who is age 26 or younger for the entire calendar year (a PPACA Dependent Child).

“Effective Date” means the date in which the Plan shall begin.

“Eligible Employee” means an Employee, as defined in Section 2.9 below, who has met the Eligibility requirements of the Plan set out in Section 3.1.

“Employee” means an individual employed by the Employer who regularly works at least **40 hours** per week, except for: (1) employees covered by a collective bargaining agreement; (2) employees who are nonresident aliens who receive no earned income from the Employer which constitutes income from sources within the United States; (3) employees who are self-employed individuals as defined in section 401(c) of the Internal Revenue Code (including sole proprietors and partners in a partnership); and (4) employees who own (or are considered to own within the meaning of Section 318 of the Internal Revenue Code) more than 2 percent of the outstanding stock of an S corporation or stock possessing more than 2 percent of the total combined voting power of all stock of such corporation.

“Employer” means COFFEE COUNTY BOARD OF EDUCATION or any of its affiliates, successors or assignors that adopt the Plan.

“Entry Date” means for each Eligible Employee, the first day of the month coincident with or next following the day that the Employee becomes eligible to participate in the Plan.

“**ERISA**” means the Employee Retirement Income Security Act of 1974, as amended. This federal law governs employer sponsored benefits. It regulates Retirement Plans as well as Health & Welfare Benefit Plans, such as group and individual medical, life, dental, and disability insurance policies.

“**GINA**” means the Genetic Information Nondiscrimination Act of 2008.”

“**Healthcare Insurance Market Place**”, means organizations that facilitate structured and competitive markets for purchasing health coverage. The Health Insurance Marketplace, or "Exchange," offers standardized health insurance plans to individuals, families and small businesses. Certain states operate their own marketplace, while others opt for a partnership exchange where the federal government manages the marketplace. In each state, various private insurance companies submit plans to be included in the marketplace.

“**Health Savings Account (H S A)**”, means an account created for individuals who are covered under high-deductible health plans (HDHPs) to save for medical expenses that HDHPs do not cover. Contributions are made into the account by the individual and/or the individual's employer and are limited to a maximum amount each year. The contributions are invested over time and can be used to pay for qualified medical expenses, which include most medical care such as dental, vision and over-the-counter drugs. H S A contributions are limited to IRS inflation-adjusted criteria determined by the IRS on an annual basis.

“**High Deductible Health Plan (HDHP)**”, means a health insurance plan with lower premiums and higher deductibles than a traditional health plan. Being covered by an HDHP is also a requirement for having a health savings account.

“**HIPAA**” means the Health Insurance Portability and Accountability Act of 1996, as amended.

“**HITECH**” means the Health Information Technology for Economic and Clinical Health Act.

“**Maximum Allowance**”, means that portion of a non-participating provider's charge which the health plan will consider in calculating benefits. The Maximum Allowance will be determined by the health plan in its sole discretion based on the health plan's determination of the contracted rates or average discount the health plan has negotiated with participating providers for a covered service. If the billed charge exceeds the Maximum Allowance, the Member is responsible for paying the non-participating provider the difference, except in the event of a medical emergency. Any amount paid in excess of the Maximum Allowance by a Member for covered services will not count toward any applicable Deductible or Maximum Out-of-Pocket.

“**Maximum Policy Benefit**”, means the maximum dollar amount of benefits for each Member payable by the health plan. The Lifetime Benefit Maximum is reached when the total of claims paid by the health Plan under all certificates of coverage for a particular Member through an employer group equals the lifetime maximum amount. All claims paid under certificates of coverage covering a Member through the employer group shall be accumulated to determine when the Member has reached the lifetime maximum.

“**Member**”, means a person covered under an insurance plan, either the enrollee or eligible dependents.

“**MHPA**” means the Mental Health Parity Act of 1996.

“**MHPAEA**” means the Mental Health Parity and Addiction Equity Act of 2008.

“Michelle’s Law” means the law that requires group health plans to allow seriously ill or injured college students who are covered dependents to continue coverage for up to one year while on medically necessary leaves of absence.

“NMHPA” means the Newborns’ and Mothers’ Health Protection Act of 1996, as amended.

“Participant” means any Employee who has met the eligibility requirements of Section 3.1 of the Plan and has elected to participate in the Plan by providing the Plan Administrator with an executed Benefits Enrollment Form.

“Patient Protection and Affordable Care Act (PPACA)”, means the United States federal statute signed into law by President Barack Obama on March 23, 2010. The law was enacted with the goals of increasing the quality and affordability of health insurance, lowering the uninsured rate by expanding public and private insurance coverage, and reducing the costs of healthcare for individuals and the government. It introduced a number of mechanisms—including mandates, subsidies, and insurance exchanges—meant to increase coverage and affordability.

“Plan” means COFFEE COUNTY BOARD OF EDUCATION Premium Conversion Plan, as described herein.

“Plan Administrator” means the Employer or such other person or committee as may be appointed by the Employer to administer the Plan.

“Plan Sponsor” means COFFEE COUNTY BOARD OF EDUCATION

“Plan Year” means the 12-consecutive-month period beginning as of the effective date of the plan.

“Premium”, means price of insurance protection for a specified period of time.

“Premium Conversion”, means an arrangement that allows employees to make a pretax contribution to an employer sponsored health or welfare plan. Premium conversion is a tax benefit. It uses federal tax rules to allow you to deduct your share of health insurance premiums from your taxable income, thereby reducing your taxes.

“Qualified Medical Child Support Order (QMCSO)”, means a court order used to enforce an order for a health plan participant to provide child support health benefits. It requires a health plan to include a child as covered under a health plan, even if the child(ren) or the participant do not meet the conditions of the health plan. A QMCSO is typically used to gain coverage for a child under a non-custodial parent's group health plan. It is normally obtained by a divorced or separated spouse or by a state child support or Medicaid agency. The order authorizes withholding the participant's share of the cost for coverage from their pay. They may not drop coverage for the child without proof that the QMCSO is no longer in effect.

“Salary Reduction Agreement” means the agreement by an Employee authorizing the Employer to reduce the Employee’s Compensation while a Participant during the Plan Year for purposes of making contributions toward Benefits under the Plan.

“Spouse” means an individual who is legally married to a Participant but shall not include an individual separated from a Participant under a decree of legal separation.

“Status Change”, means a change in employee’s marital status; a change in employment status; a change in the number of dependents; a dependent ceasing to satisfy dependent eligibility requirements; a change in residence; and commencement or termination of adoption proceedings. Any election change allowable under the meaning of a “status change” must be on account of and correspond with a change that affects eligibility for coverage under an employer’s plan (including a change in status that results in an increase or decrease in the number of an employee’s family members or dependents who may benefit from coverage under the plan).

“Summary of Benefits & Coverage (SBC)”, means a mandated provision of the Affordable Care Act, wherein health insurers and group health plans must provide communication material that is clear, consistent and comparable information about their health plan benefits and coverage. The regulations are to ensure that consumers have access to sufficient information to help them understand and evaluate their health insurance choices. The SBC must also contain a uniform glossary of terms commonly used in health insurance coverage such as “deductible” and “co-payment”.

“Summary of Material Modification (SMM)”, means a required notice under ERISA when changes to the plan are considered “material”. Plan changes that are considered material include all changes in any of the information required to be included in the SPD.

“Summary Plan Description (SPD)”, means the primary informational document issued to plan beneficiaries to inform them of their rights and obligations under a plan. The plan should be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive. ERISA mandates that an SPD be specific enough to enable the ordinary employee to sense when there is a danger that benefits could be lost or diminished.

