



**Monday, August 27, 2018, 3:00 PM**

Tele-Conference

Conference Dial: 1-800-511-7985

Conference Code: 605-9608#

## **Special Executive Committee** Agenda

- I. **Welcome and Introductions** .....Sean Butler, Chair
  
- II. **Public Comments**
  
- III. **Action Items**
  - 1. Employee Handbook Update ..... Page 2
  - 2. Cigna Group Benefits Plan ..... Page 3
  - 3. Section 125 Cafeteria Plan and Form 550 Wrap Documents ..... Page 4
  
- IV. **Adjournment**

Next Executive Committee Meeting    October 18, 2018





## Action Item

### Employee Handbook

The employee handbook is being updated and refined in preparation for the hiring and rehiring of employees effective September 1<sup>st</sup>, 2018.

#### Summary of Changes

Section	Page (All Markup View)	Section	Page (All Markup View)
Equal Employment Opportunity	14	Accommodations Related to Dress Code Policy	52
Immigration Reform and Control Act	14	Use of Electronic Media	52
Disability Accommodation	15	Company Cell Phone Policy	60
Employee Nepotism and Fraternalization	19	Safe Driving Policy	63
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Parking	50	FMLA	80
Tattoos	52	Employee Rights	85

### Recommendation

Approval of the Employee Handbook.



## Action Item

### Cigna Group Insurance Benefits Plan

Cigna is requesting a rate adjustment on group employee benefits effective September 1, 2018. Consequently, staff has conducted an analysis of the group Life, Short Term Disability, and Long Term Disability. The result of their analysis is provided in the matrix below:

**Analysis of change in employee premiums due to transition**

Period for Analysis	9/1/2018	12/31/2018	
Employee Benefit	Est. Premiums at New Rate	Est. Premiums at Current Rate	Est. Amount to be covered by CSTB
Basic Life Insurance	2,025.00	1,735.00	290.00
Long Term Disability	3,550.00	3,175.00	375.00
Short Term Disability	7,020.00	6,735.00	285.00
<b>Totals</b>	<b>12,595.00</b>	<b>11,645.00</b>	<b>950.00</b>

*Note: The above amounts are estimates based on available data for current employees as of the time of the analysis. Amounts may vary once final employee elections are known.*

The total cost of the increase, based on our estimated enrollment, is \$950 for the period of September 1<sup>st</sup> thru December 31<sup>st</sup>. The rate adjustment will not increase employee payroll deductions during this time period.

There will be a rate adjustment on the Medical, Dental, and Vision plans effective January 1, 2019. The employee contributions will be adjusted at that time.

In the best interest of the employees, staff is requesting that the Board approve the payment of \$950 as a business expense and not increase employee payroll deductions at this time.

### **Recommendation**

Approval of the rate adjustment in the amount of \$950 for Cigna Group Insurance Benefits Plan.



## **Action Item**

### **Section 125 Cafeteria Plan and Form 550 Wrap Documents**

#### **Section 125**

The Section 125 documents allows employees to pay for their group insurance contributions pre-tax. They also establish the health care and dependent care flexible spending accounts. These are all current benefits that transitioning employees have currently as employees of WorkNet Pinellas.

#### **Wrap Plan Documents**

The Wrap Plan document is the master employee benefit plan document which allows CareerSource Tampa Bay to file one combined annual Form 5500 with the IRS. Without this document, staff would need to file separate Form 5500 forms for each employee benefit plan, i.e., medical, dental, vision, life, etc. This document reduces administration and provides a high level overview of benefits eligibility, definitions, etc. This plan must be adopted by the Board prior to September 1<sup>st</sup>.

These documents are currently under review by corporate attorneys. If the review is not completed in time for the August 27<sup>th</sup> Special Executive Committee Meeting, staff is recommending that the Board approve these documents. Any amendments will be presented to the Board in the future.

Staff is seeking for Board approval to adopt these plans prior to September 1, 2018.

#### **Attachments:**

- Employee Health & Welfare Plan – Wrap Plan, Pages 5 – 45 of the packet
- Employee Health & Welfare Plan – Wrap Summary Plan Description, Pages 46 – 81
- SBC Distribution Options, Pages 82 – 84
- Flexible Spending Account – Plan Document, Pages 85 – 127
- Flexible Spending Account – Summary Plan Description, Pages 128 - 154

#### **Recommendation**

Approval of Section 125 Plan, Wrap Summary Plan Description, and Form 550 Wrap Plan document.

# CareerSource Tampa Bay Employee Health & Welfare Plan

WRAP PLAN

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*Note to Plan Administrator/Sponsor:*

ERISA requires an employer to have a written Plan Document and Summary Plan Description (SPD) for each separate Welfare Benefit Plan. These documents must contain very specific information as required by law. However, the certificates of coverage (COCs or “booklet-certificates”) provided by insurance carriers do not typically contain all of the required ERISA language. In order to maintain compliance with ERISA, it is customary for employers to add a Wrap SPD to the certificates of coverage. In combination, the certificates of coverage and this Wrap SPD form a complete Summary Plan Description in conformity with ERISA requirements.

## **ERISA PLAN NUMBER 501**

ERISA Plan Year **January 1 - December 31**

Established as of **January 1, 2018**  
Amended and Restated as of **September 1, 2018**



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**CareerSource Tampa Bay**  
**Employee Health & Welfare Plan**

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**ARTICLE 1**  
**VARIABLE PROVISIONS/DEFINITIONS**

**Section 1.01   DEFINITIONS**

- "Affiliated Employer"** means any corporation which adopts the Plan and is a member of a controlled group of corporations (as defined in Code Section 414(b)) which includes the Employer; any trade or business (whether or not incorporated) which is under common control (as defined in Code Section 414(c)) with the Employer; any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Employer; and any other entity required to be aggregated with the Employer pursuant to Treasury regulations under Code Section 414(o).
- "Business Associate"** means any outside vendor who performs a function or activity on behalf of the Plan which involves the creation, use or disclosure of PHI, and includes any subcontractor to whom a Business Associate delegates its obligations.
- "COBRA"** means the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986, as amended.
- "Dependent"** means any person who qualifies as a dependent under a Subsidiary Contract for purposes of that contract.
- "Eligible Employee"** is an employee of the Employer who meets the eligibility requirements for one or more of the benefits offered under this Plan. It is expressly intended that individuals not treated as common law employees by the Employer on its payroll records are not Eligible Employees and are excluded from Plan participation even if a court or administrative agency determines that such individuals are common law employees and not independent contractors.
- "Employer"** means the Plan Sponsor and any other entity that adopts the Plan with the consent of the Plan Sponsor.
- "ERISA"** means the Employee Retirement Income Security Act of 1974, as amended from time to time.
- "FMLA"** means the Family Medical Leave Act, as referenced under Public Law 103-3 enacted February 5, 1993, and as amended.
- "HIPAA"** means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.



- "Individual"** as referenced in Article 8, means the Participant or the Participant's covered dependents enrolled in any of the group health benefits under the Plan. This definition does not apply to the term, "individual," as referenced in other articles of this document.
- "Initial Administrative Period"** means the time during which new Variable Hour Employees who have completed the Initial Measurement Period and have been determined to be Eligible Employees can enroll in or waive medical coverage. This period may not exceed ninety (90) days and may include a partial month prior to the beginning of the Initial Measurement Period. The Initial Administrative Period, or its second part, begins the next day after the end of the Initial Measurement Period.
- "Initial Measurement Period"** means the period of time during which a new Variable Hour Employee's hours of service are measured to determine whether the employee will become an Eligible Employee.
- "Initial Stability Period"** means the minimum period of time during which medical coverage must be offered to an employee who was previously a Variable Hour Employee and has been determined to be an Eligible Employee. The Initial Stability Period may not be shorter in duration than the Initial Measurement Period.
- "Notice of Privacy Practices"** means a notice explaining the uses and disclosures of PHI that may be made by the Plan, the covered Individuals' rights under the Plan with respect to PHI, and the Plan's legal duties with respect to PHI.
- "Ongoing Employee"** means an employee who was employed with the Employer on the first day of a Standard Measurement Period.
- "Participant"** means an employee of the Employer that participates in one or more Subsidiary Contracts.
- "PHI"** or Protected Health Information means information about an Individual, including genetic information, (whether oral or recorded in any form or medium) that (1) is created or received by the Plan or the Plan Sponsor; (2) relates to the past, present or future physical or mental health or condition of the Individual, the provision of health care to the Individual, or the past, present or future payment for the provision of health care to the Individual; and (3) identifies the Individual or with respect to which there is a reasonable basis to believe the information may be used to identify the Individual. PHI includes Protected Health Information that is transmitted by or maintained in electronic media.

<b>"Placed for Adoption"</b>	The phrase refers to a child whom the Participant intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement of adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child.
<b>"Plan"</b>	means the benefit programs that are described in this document, including all amendments thereto.
<b>"Plan Administration Functions"</b>	means the administration functions performed by the Plan Sponsor on behalf of the Plan. Plan Administration Functions do not include functions performed by the Plan Sponsor in connection with any other benefit plan of the Plan Sponsor.
<b>"Plan Year"</b>	means each 12-consecutive month period ending on: <b><u>December 31</u></b> .
<b>"Seasonal Employee"</b>	means an employee who is hired for a position for which the customary annual employment period is six (6) months or less and which begins at approximately the same time of each calendar year. A Seasonal Employee will be treated as a Variable Hour Employee with respect to eligibility.
<b>"Spouse"</b>	refers to an individual who is lawfully married under any state law or currently recognized under prevailing Federal law. This definition shall apply to the extent it is not inconsistent with the provisions of any applicable Subsidiary Contract, in which case the provisions of the Subsidiary Contract shall control.
<b>"Standard Administrative Period"</b>	means the time during which Ongoing Employees who have completed the Standard Measurement Period can enroll in or disenroll from medical coverage. This period occurs between the Standard Measurement Period and the Standard Stability Period and may neither reduce nor lengthen the Measurement Period or the Stability Period.
<b>"Standard Measurement Period"</b>	means the period during which the Employer counts each Ongoing Employee's hours of service. Such period cannot be less than three (3) months nor more than twelve (12) months.
<b>"Standard Stability Period"</b>	means the period of time during which an Ongoing Employee is eligible for medical coverage under the Plan. The Standard Stability Period may not be shorter in duration than the Standard Measurement Period.
<b>"Subsidiary Contract"</b>	means any agreement, writing, contract, plan or arrangement between the Employer and a welfare benefit provider, or any other statements of coverage provided by the Plan Administrator setting forth a description of the scope of coverage, where the benefits provided are subject to ERISA.

**"Summary Health Information"** means information summarizing the claims history, claims expenses, or types of claims experienced by an Individual, and from which the following information has been removed: (1) names; (2) any geographic information which is more specific than a five digit zip code; (3) all elements of dates relating to a covered Individual (e.g., birth date) or any medical treatment (e.g., admission date) except the year; all ages for a covered Individual if the Individual is over age 89 and all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older); (4) other identifying numbers, such as, Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, or serial numbers; (5) facial photographs or biometric identifiers (e.g., finger prints); and (6) any other unique identifying number, characteristic, or code.

**"USERRA"** means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

**"Variable Hour Employee"** means an employee for whom the Employer is not able to determine, at the employee's hire date, whether the employee is reasonably expected to work the required number of hours per week for eligibility, as described in Article 1, Section 1.05.

**"Waiting Period"** means the time period during which a newly hired Eligible Employee must be employed by the Employer prior to becoming a Participant.

**"Welfare Benefit Plan"** means any plan, fund, or program which was heretofore or is hereafter established or maintained by the Employer, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its Participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in 29 U.S. Code § 186(c) (other than pensions on retirement or death, and insurance to provide such pensions).

## Section 1.02 PLAN INFORMATION

This Plan is intended to qualify as a Welfare Benefit Plan of the Employer under ERISA.

### General Plan Information

- (a) Name of Plan Sponsor: **Tampa Bay Workforce Alliance, Inc. DBA CareerSource Tampa Bay**
- (b) Plan name: **CareerSource Tampa Bay Employee Health & Welfare Plan**
- (c) Plan number: **501**
- (d) Plan Effective Date: **January 1, 2018**
- (e) Document Effective Date: **September 1, 2018**. This is a restatement of the Plan.
- (f) The Plan Administrator shall be the **Plan Sponsor**. The Plan Administrator shall also be the primary named fiduciary within the meaning of ERISA section 402.
- (g) For insured Subsidiary Contracts, the insurance company is a named fiduciary as it relates to the determination of the amount of, and entitlement to, the insured benefits. The insurance company shall maintain full power to interpret and apply the terms relevant to its benefits policy.

## Section 1.03 INDEMNIFICATION

The Employer shall indemnify and hold harmless any person serving as the Plan Administrator (and its delegate) from all claims, liabilities, losses, damages and expenses, including reasonable attorneys' fees and expenses, incurred by such persons in connection with their duties hereunder to the extent not covered by insurance, except when the same is due to such person's own gross negligence, willful misconduct, lack of good faith, or breach of its fiduciary duties under this Plan or ERISA.

## Section 1.04 SUBSIDIARY CONTRACTS

Subsidiary Contracts shall include and are not limited to the terms of the Welfare Benefit Plans listed in Appendix A. In addition, any statements of coverage provided by the Plan Administrator setting forth a description of the scope of coverage under the Plan as well as the options, terms, conditions and limitations related thereto are herein incorporated as part of the Subsidiary Contracts.

Section 1.05 ELIGIBILITY

- (a) Eligibility for Medical Benefits
- (i) The following provisions apply only with respect to eligibility for medical benefits under the Plan. To the extent that this Section conflicts with any provision in the Plan or a subsidiary Contract, the terms of this Section shall control.
  - (ii) The Employer offers coverage to Eligible Employees, their Spouses, and Dependents.
  - (iii) The eligibility terms and conditions that apply to a Participant's biological children will also apply to Dependents who have been adopted or Placed for Adoption with a Participant.
  - (iv) An Employee (who is not a Seasonal Employee) who regularly works, or is expected to work, 30 hours or more per week on average shall be an Eligible Employee.
  - (v) The Waiting Period applicable to a newly hired Eligible Employee shall end the first of the month following 30 days after his initial date of employment with the Employer. Participation shall not begin prior to this date.
  - (vi) However, any Employee who works, or is expected to work on a regular basis, less than 30 hours per week on average, and is not designated as an Eligible Employee on the Employer's personnel records, shall not be eligible to participate in the Plan.
- (vii) Enrollment
- i. Newly hired Eligible Employees may participate in the Plan following completion of the Waiting Period.
  - ii. Variable Hour Employees who become Eligible Employees may participate in the Plan following completion of the Initial Administrative Period.
  - iii. Ongoing Employees who become Eligible Employees may participate in the Plan following completion of the Standard Administrative Period.
- (viii) Healthcare Reform Provisions for Group Health Plan
- i. The Employer intends to follow IRS regulations and any subsequent guidance when administering the measurement, administrative, and stability periods.

ii. Variable Hour Employees

Variable Hour Employees must first complete an Initial Measurement Period during which they are not eligible to enroll in medical benefits under the Plan. At the end of the Initial Measurement Period, if the employee is determined to be an Eligible Employee, that employee will be eligible for medical benefits under the Plan. The Employer will use the Initial Administrative Period to determine whether an employee is an Eligible Employee and to offer coverage to Eligible Employees during the enrollment period specified by the Plan Administrator. Coverage will be effective during the Initial Stability Period.

(b) All Other Benefits Eligibility

Unless otherwise here stated, the eligibility requirements of each separate welfare benefit can be found in the applicable Subsidiary Contract. To the extent that this Section conflicts with any provision in the Plan or a Subsidiary Contract, the terms of this Section shall control.

## **ARTICLE 2 BENEFITS**

### **Section 2.01 INCORPORATION BY REFERENCE**

The actual terms and conditions of the Subsidiary Contracts offered under this Plan are contained in separate, written documents governing each respective benefit, and, unless otherwise stated herein, shall govern in the event of a conflict between the individual plan document and this Plan. To that end, each such separate Subsidiary Contract, as amended or subsequently replaced, is hereby incorporated by reference as if fully recited herein.

See other Welfare Benefit Plan documents, summary plan descriptions, and/or certificates of coverage that are component parts which apply to this plan.

**ARTICLE 3**  
**PLAN ADMINISTRATION**

**Section 3.01 PLAN ADMINISTRATOR**

(a) Designation. The Plan Administrator shall be specified in Article 1. In the absence of a designation in Article 1, the Plan Sponsor shall be the Plan Administrator. If a Committee is designated as the Plan Administrator, the Committee shall consist of one or more individuals who may be employees appointed by the Plan Sponsor and the Committee shall elect a chairman and may adopt such rules and procedures as it deems desirable. The Committee may also take action with or without formal meetings and may authorize one or more individuals, who may or may not be members of the Committee, to execute documents in its behalf.

(b) Authority and Responsibility of the Plan Administrator. The Plan Administrator shall be the Plan "administrator" as such term is defined in section 3(16) of ERISA, and as such shall have total and complete discretionary power and authority:

(i) to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities and inconsistencies therein and to supply omissions thereto. Any construction, interpretation or application of the Plan by the Plan Administrator shall be final, conclusive and binding;

(ii) to determine the amount, form or timing of benefits payable hereunder and the recipient thereof and to resolve any claim for benefits in accordance with Article 5;

(iii) to determine the amount and manner of any allocations hereunder;

(iv) to maintain and preserve records relating to the Plan;

(v) to prepare and furnish all information and notices required under applicable law or the provisions of this Plan;

(vi) to prepare and file or publish with the Secretary of Labor, the Secretary of the Treasury, their delegates and all other appropriate government officials all reports and other information required under law to be so filed or published;

(vii) to hire such professional assistants and consultants as it, in its sole discretion, deems necessary or advisable; and shall be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by same;



(viii) to determine all questions of the eligibility of employees and of the status of rights of Participants under the Plan;

(ix) to determine the validity of any judicial order;

(x) to retain records on elections and waivers by Participants;

(xi) to supply such information to any person as may be required;

(xii) to perform such other functions and duties as are set forth in the Plan that are not specifically given to any other fiduciary or other person.

(c) Procedures. The Plan Administrator may adopt such rules and procedures as it deems necessary, desirable, or appropriate for the administration of the Plan. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished to it. The Plan Administrator's decisions shall be binding and conclusive as to all parties.

(d) Allocation of Duties and Responsibilities. The Plan Administrator may designate other persons to carry out any of his duties and responsibilities under the Plan.

(e) Compensation. The Plan Administrator shall serve without compensation for its services.

(f) Expenses. All direct expenses of the Plan, the Plan Administrator and any other person in furtherance of their duties hereunder shall be paid or reimbursed by the Employer.

(g) Allocation of Fiduciary Duties. A Plan fiduciary shall have only those specific powers, duties, responsibilities and obligations as are explicitly given him under the Plan. It is intended that each fiduciary shall not be responsible for any act or failure to act of another fiduciary. A fiduciary may serve in more than one fiduciary capacity with respect to the Plan.

### Section 3.02 MEDICAL CHILD SUPPORT ORDERS

In the event the Plan Administrator receives a medical child support order (within the meaning of ERISA section 609(a)(2)(B)), the Plan Administrator shall notify the affected Participant and any alternate recipient identified in the order of the receipt of the order and the Plan's procedures for determining whether such an order is a qualified medical child support order (within the meaning of ERISA section 609(a)(2)(A)). Within a reasonable period, the Plan Administrator shall determine whether the order is a qualified medical child support order and shall notify the Participant and alternate recipient of such determination.

### Section 3.03 THIRD PARTY RECOVERY/REIMBURSEMENT

(a) The Plan Administrator may, but is not required to, utilize the provisions of this subsection to the extent not inconsistent with the provisions of any applicable Subsidiary Contract, in which case the provisions of the Subsidiary Contract shall control.

(b) In General. When a Participant or covered dependent receives Plan benefits which are related to medical expenses that are also payable under workers' compensation, any statute, any uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy or any other plan of benefits, or when related medical expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement or for any other reason, the Participant shall reimburse the Plan for the related Plan benefits received out of any funds or monies the Participant recovers from any third party.

(c) Specific Requirements and Plan Rights. Because the Plan is entitled to reimbursement, the Plan shall be fully subrogated to any and all rights, recovery or causes of actions or claims that a Participant or covered dependent may have against any third party. The Plan is granted a specific and first right of reimbursement from any payment, amount or recovery from a third party. This right to reimbursement is regardless of the manner in which the recovery is structured or worded, and even if the Participant or covered dependent has not been paid or fully reimbursed for all of their damages or expenses.

The Plan's share of the recovery shall not be reduced because the full damages or expenses claimed have not been reimbursed unless the Plan agrees in writing to such reduction. Further, the Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence or any other equitable defenses that may affect the Plan's right to subrogation or reimbursement.

The Plan may enforce its subrogation or reimbursement rights by requiring the Participant to assert a claim to any of the benefits to which the Participant or a covered dependent may be entitled. The Plan will not pay attorneys' fees or costs associated with the claim or lawsuit without express written authorization from the Employer.

If the Plan should become aware that a Participant or covered dependent has received a third party payment, amount or recovery and not reported such amount, the Plan, in its sole discretion, may suspend all further benefits payments related to the Participant and covered dependents until the reimbursable portion is returned to the Plan or offset against amounts that would otherwise be paid to or on behalf of the Participant or covered dependents.

(d) Participant Duties and Actions. By participating in the Plan each Participant and covered dependent consents and agrees that a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. In accordance with that constructive trust, lien or equitable lien by agreement, each Participant and covered dependent agrees to cooperate with the Plan in reimbursing it for Plan costs and expenses.

Once a Participant or covered dependent has any reason to believe that the Plan may be entitled to recovery from any third party, the Participant must notify the Plan. And, at that time, the Participant (and the Participant's attorney, if applicable) must sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle the Participant or covered dependent to any payment, amount or recovery from a third party.

If a Participant fails or refuses to execute the required subrogation/reimbursement agreement, the Plan may deny payment of any benefits to the Participant or covered dependent until the agreement is signed. Alternatively, if a Participant fails or refuses to execute the required subrogation/reimbursement agreement and the Plan nevertheless pays benefits to or on behalf of the Participant or a covered dependent, the Participant's acceptance of such benefits shall constitute agreement to the Plan's right to subrogation or reimbursement.

Each Participant and covered dependent consents and agrees that they shall not assign their rights to settlement or recovery against a third person or party to any other party, including their attorneys, without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Plan.

#### Section 3.04 HIPAA PORTABILITY RULES

To the extent the Plan constitutes a group health plan as defined in Treas. Reg. section 54.9801-2 or if the Plan Administrator determines that the Plan is subject to HIPAA portability rules, the Plan shall comply with the requirements of Code section 9801 et. seq. including the requirement to cover children until the attainment of at least age 26 if the Plan makes dependent coverage of children available.

#### Section 3.05 MEDICAID

If a group health plan is subject to ERISA § 609(b), then this Section shall apply.

Payment for benefits with respect to a Participant under a group health plan will be made in accordance with any assignment of rights made by or on behalf of such Participant or a

beneficiary of the Participant as required by a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993).

The fact that a Participant is eligible for or is provided medical assistance under a state plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account in enrolling such Participant or in determining or making benefit payments for such Participant.

To the extent that payment has been made under a state plan for medical assistance approved under Title XIX of the Social Security Act in any case in which a group health plan has a legal liability to make payment for items or services constituting such assistance, payment for benefits under such program will be made in accordance with any state law which provides that the state has acquired the rights with respect to a Participant to such payment for such items or services.

### Section 3.06 COORDINATION OF BENEFITS

(a) Applicability. If a Participant has health care coverage under more than one Arrangement (defined, for purposes of this Section, below), the following coordination of benefits rules shall apply to the extent the applicable Subsidiary Contract does not contain coordination of benefits rules. If an applicable Subsidiary Contract contains coordination of benefits rules, the rules of the Subsidiary Contract shall apply and shall supersede this section.

(b) General Rule. The primary Arrangement pays or provides benefits as if the secondary Arrangement does not exist. An Arrangement may consider the benefits paid or provided by another Benefit in determining its benefits only when it is secondary to that other Arrangement. A secondary Arrangement pays after the primary Arrangement and may reduce the benefits it pays so that payments from all Arrangements do not exceed 100% of the total Allowable Expense (defined, for purposes of this Section, below). The order of benefit determination rules determine which Arrangement is primary or secondary.

(c) Definitions. For purposes of this Section, the following definitions apply:

(i) Allowable Expense. Allowable Expense means a health care service or expense, including coinsurance and copayments and without reduction of any applicable deductible, that is covered at least in part by any of the Arrangements covering the person. When an Arrangement provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the Arrangements is not an Allowable Expense. Any expense that a health care provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense. If a person is covered by one Arrangement that computes its benefit payments on the basis of

reasonable or recognized charges and another Arrangement that provides its benefits or services on the basis of negotiated charges, the primary Arrangement's payment arrangements shall be the Allowable Expense for all the Arrangements. However, if the secondary Arrangement has a negotiated fee or payment amount different from the primary Arrangement and if the provider contract permits, that negotiated fee will be the Allowable Expense used by the secondary Arrangement to determine benefits. When an Arrangement provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed an Allowable Expense and a benefit paid.

(ii) Arrangement. An Arrangement includes any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Arrangement and there is no coordination of benefits among those separate contracts.

Arrangement includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, Closed Panel Arrangements (defined, for purposes of this Section, below) or other forms of group or group-type coverage (whether insured or uninsured); medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

Arrangement does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage included or excluded above is a separate Arrangement. If an Arrangement has two parts and coordination of benefits rules apply to only one of the two, each of the parts is treated as a separate Arrangement.

(iii) Closed Panel Arrangement. A Closed Panel Arrangement is an Arrangement that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Arrangement, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

(iv) Custodial Parent. A Custodial Parent is a parent awarded custody by a court decree. In the absence of a court decree, the Custodial Parent is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

(d) Order of Benefit Determination. Except as provided in the following sentence, an Arrangement that does not contain a coordination of benefits provision is always primary. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Arrangement provided by the contract holder. Examples include major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connected with a Closed Panel Arrangement to provide out-of-network benefits.

Each Arrangement that contains a coordination of benefits provision, and that does not meet the exception above, determines its order of benefits using the first of the following rules that apply:

(i) Non-dependent or Dependent. The Arrangement that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the primary Arrangement and the Arrangement that covers the person as a dependent is the secondary Arrangement. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Arrangement covering the person as a dependent; and primary to the Arrangement covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the Arrangements is reversed so that the Arrangement covering the person as other than a dependent is the secondary Arrangement and the other Arrangement is the primary Arrangement.

(ii) Dependent Child Covered Under More Than One Arrangement. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Arrangement, the order of benefits is determined as follows:

(A) For a dependent child whose parents are married or are living together, whether or not they have ever been married: the Arrangement of the parent whose birthday falls earlier in the calendar year is the primary Arrangement; or, if both parents have the same birthday, the Arrangement that has covered the parent the longest is the primary Arrangement.

(B) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Arrangement of that parent has actual knowledge of those terms, that Arrangement is primary. This rule applies to plan years commencing after the Arrangement is given notice of the court decree.

(2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage or the decree does not specify which parent is responsible for the dependent child's health care expenses or health care coverage, the provisions of Subsection 3.06(d)(ii)(A) shall determine the order of benefits;

(3) If there is no court decree allocating responsibility for the health care expenses/coverage of the dependent child, the order of benefits for the child is as follows: (I) The Arrangement covering the Custodial Parent (defined, for purposes of this Section, above); (II) The Arrangement covering the spouse of the Custodial Parent; (III) The Arrangement covering the non-Custodial Parent; and then (IV) The Arrangement covering the spouse of the non-Custodial Parent.

(C) For a dependent child covered under more than one Arrangement of individuals who are not the parents of the child, the order of benefits should be determined as outlined above as if the individuals were the parents.

(iii) Active Employee or Retired or Laid off Employee. The Arrangement that covers a person as an employee who is neither laid off nor retired or as a dependent of an active employee, is the primary Arrangement. The Arrangement covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the secondary Arrangement. If the other Arrangement does not have this rule, and if, as a result, the Arrangements do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

(iv) Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Arrangement, the Arrangement covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Arrangement does not have this rule, and if, as a result, the Arrangements do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

(v) Longer or Shorter Length of Coverage. The Arrangement that covered the person as an employee, member, or subscriber longer is primary.

(vi) If the preceding rules do not determine the primary Arrangement, the Allowable Expenses shall be shared equally between the Arrangements meeting the definition of Arrangement under this Section. Any Subsidiary Contract will not pay more than it would have paid had it been primary.

(e) Effect on the Arrangements. When an Arrangement is secondary, it may reduce its benefits so that the total benefits paid or provided by all Arrangements during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any

claim, the secondary Arrangement will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Arrangement that is unpaid by the primary Arrangement. The secondary Arrangement may then reduce its payment by the amount so that, when combined with the amount paid by the primary Arrangement, the total benefits paid or provided by all Arrangements for the claim do not exceed the total Allowable Expense for that claim. In addition, the secondary Arrangement shall credit to its Arrangement deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If a covered person is enrolled in two or more Closed Panel Arrangements and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Arrangement, coordination of benefits shall not apply between that Arrangement and other Closed Panel Arrangements.

(f) Right to Receive and Release Needed Information. Certain facts about health care coverage and services are needed to apply these coordination of benefits rules and to determine benefits under the Arrangements. The Arrangements have the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision. The Arrangements need not tell, or get the consent of, any person to do this. Each person claiming benefits under the Arrangements must give the Arrangements any facts it needs to apply those rules and determine benefits payable.

(g) Facility of Payment. Any payment made under an Arrangement may include an amount, which should have been paid under another Arrangement. If so, the Arrangement may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under paying Arrangement. No Arrangement will have to pay that amount again. The term “payment made” means reasonable cash value of the benefits provided in the form of services.

(h) Right of Recovery. If the amount of the payments made by an Arrangement is more than it should have paid under this coordination of benefits provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

### Section 3.07 FMLA/USERRA

To the extent the Employer is subject to FMLA, the Plan Administrator shall permit a Participant taking unpaid leave under the FMLA to continue medical benefits under such applicable law. Non-medical benefits shall be continued according to the established policy of the Employer. Participants continuing participation pursuant to the foregoing shall pay for such



coverage (on a pre-tax or after-tax basis) under a method as determined by the Plan Administrator satisfying Treas. Reg. 1.125-3 Q&A-3. Any Participant on FMLA leave who revoked coverage shall be reinstated to the extent required by Treas. Reg. 1.125-3. If the Participant's coverage under the Plan terminates while the Participant is on FMLA leave, the Participant is not entitled to receive reimbursements for claims incurred during the period when the coverage is terminated. Upon reinstatement into the Plan upon return from FMLA leave, the Participant has the right to (i) resume coverage at the level in effect before the FMLA leave and make up the unpaid premium payments, or (ii) resume coverage at a level that is reduced by the amount of unpaid premiums and resume premium payments at the level in effect before the FMLA leave.

The Plan Administrator shall also permit Participants to continue benefit elections as required under USERRA and shall provide such reinstatement rights as required by such law. The Plan Administrator shall also permit Participants to continue benefit elections as required under any other applicable state law to the extent that such law is not pre-empted by federal law.

#### Section 3.08 COBRA

To the extent the Plan is subject to COBRA (Code section 4980B and other applicable state law), a Participant shall be entitled to continuation coverage with respect to his or her health benefits as prescribed in Code section 4980B (and the regulations thereunder) or such applicable state statutes.

## ARTICLE 4 FUNDING

### Section 4.01 NO FUNDING REQUIRED

Except as otherwise required by law:

(a) Any amount contributed by a Participant and/or the Employer to provide benefits hereunder shall remain part of the general assets of the Employer and all payments of benefits under the Plan shall be made out of the general assets of the Employer or the Subsidiary Contracts.

(b) The Employer shall have no obligation to set aside any funds, establish a trust, or segregate any amounts for the purpose of making any benefit payments under this Plan. However, the Employer may in its sole discretion, set aside funds, establish a trust, or segregate amounts for the purpose of making any benefit payments under this Plan.

(c) No person shall have any rights to, or interest in, any account other than as expressly authorized in the Plan.

### Section 4.02 FUNDING POLICY

The Employer shall have the right to enter into a contract with one or more Subsidiary Contract providers for the purposes of providing any benefits under the Plan and to replace any of such Subsidiary Contracts. The Employer will not be liable for any loss or obligation relating to any insurance coverage except as is expressly provided by this Plan. Such limitation shall include, but not be limited to, losses or obligations that pertain to the following:

(a) Once a Subsidiary Contract is applied for or obtained, the Employer will not be liable for any loss which may result from the failure to pay premiums to the extent premium notices are not received by the Employer;

(b) To the extent premium notices are received by the Employer, the Employer's liability for the payment of such premiums will be limited to such premiums and will not include liability for any other loss which results from such failure;

(c) When employment ends, the Employer will have no liability to take any step to maintain any policy in force except as may be specifically required otherwise in this Plan and the Employer will not be liable for or responsible to see to the payment of any premium with respect to periods after employment ends.

#### Section 4.03 SUBSIDIARY CONTRACT REBATES FOR FULLY-INSURED GROUP HEALTH PLANS

Any dividends, retroactive rate adjustments or other refunds of any type, including medical loss ratio rebates required under Section 2718 of the Public Health Service Act (hereinafter collectively referred to as "rebates" for purposes of this section) that may become payable under any such Subsidiary Contract shall not be assets of the Plan except to the extent such amounts can be attributed to Participant contributions. For example: a) if the Participants and the Employer each paid a fixed percentage of the cost, a percentage of the rebate equal to the percentage of the cost paid by Participants shall be Plan assets; b) if the Employer was required to pay a fixed amount and Participants were responsible for paying any additional costs, then the portion of the rebate under such a Subsidiary Contract that does not exceed the Participants' total amount of prior contributions during the relevant period shall be Plan assets; and c) if Participants paid a fixed amount and the Employer was responsible for paying any additional costs, then the portion of the rebate under such Subsidiary Contract that does not exceed the Employer's total amount of prior contributions during the relevant period shall not be Plan assets. Any rebates that are not categorized as Plan assets may be retained by the Employer.

The Plan Administrator may hold the rebated Plan assets in trust, refund the rebate to Participants, apply the rebate towards future premiums, or take other such action in accordance with his or her fiduciary judgment and in accordance with applicable timing and other requirements of Department of Labor Technical Release No. 2011-04 and any superseding guidance. In addition, if the rebate is a medical loss ratio rebate under Section 2718 of the Public Health Service Act, the Plan Administrator shall determine whether reporting of the rebate to the Centers for Medicare and Medicaid Services (CMS) is required.

## **ARTICLE 5 CLAIMS PROCEDURES**

### **Section 5.01 CLAIMS PROCEDURES**

(a) This Section 5.01 shall apply for any claim for benefits under a Subsidiary Contract unless the Subsidiary Contract has a claims procedure that is compliant with ERISA section 503. If the Subsidiary Contract has a claims procedure that is compliant with ERISA section 503, the claims procedure of the Subsidiary Contract shall govern.

A request for benefits is a "claim" subject to these procedures only if it is filed by the Participant or the Participant's authorized representative in accordance with the Plan's claim filing guidelines. In general, claims must be filed in writing (except urgent care claims, which may be made orally) with the applicable Subsidiary Contract provider. Any claim that does not relate to a specific benefit under the Plan (for example, a general eligibility claim or a dispute involving a mid-year election change) must be filed with the Plan Administrator. A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined, at the Plan Administrator's sole discretion, that the inquiry is an attempt to file a claim. If a claim is received, but there is not enough information to process the claim, the Participant will be given an opportunity to provide the missing information.

Participants may designate an authorized representative if written notice of such designation is provided to the applicable provider identifying such authorized representative. In the case of a claim for medical benefits involving urgent care, a health care professional who has knowledge of the Participant's medical condition may act as an authorized representative with or without prior notice.

(b) **Timing of Notice of Claim.** The Plan Administrator shall notify the claimant of any adverse benefit determination within a reasonable period of time, but not later than the time frame below, depending on the type of benefit being provided under the Subsidiary Contract under which the claim for benefits arises.

(i) **In General.** Notice of an adverse benefit determination will be provided 90 days after receipt of the claim. This period may be extended one time by the Plan for up to 90 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 90-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

(ii) **Group Health Plan Claims.** The timeframe for benefit determinations under group health plans shall be determined as provided under DOL Reg. section 2560.503-1(f)(2).

(A) **Urgent Care Claims.** An "urgent care" claim is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Participant or the ability of the Participant to regain maximum function, or, in the opinion of a physician with knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Whether a claim is an "urgent care" claim is determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine. Any claim that a physician with knowledge of the Participant's medical condition determines is an "urgent care" claim will be treated as an "urgent care" claim by the Plan.

If the Participant or the Participant's authorized representative fails to follow the Plan's procedures for filing a urgent care claim, the Plan Administrator (or its delegate) will notify the Participant of the failure as soon as possible, but not later than 24 hours following the failure and of the proper procedures to be followed in filing a claim for benefits. Notification may be oral, unless written notification is requested by the Participant or authorized representative. This paragraph (A) applies only to a communication by a Participant or an authorized representative that is received by a person or organizational unit customarily responsible for handling benefit matters; and that names a specific Participant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

The Plan Administrator will notify the Participant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the Participant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the plan administrator will notify the Participant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The Participant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan Administrator will notify the claimant of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified information, or (2) the end of the period afforded the Participant to provide the specified additional information.

(B) **Pre-Service Claims.** A "pre-service" claim is any claim for a benefit under a group health plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. If the Participant or the Participant's authorized representative fails to follow the Plan's

procedures for filing a pre-service claim, the Plan Administrator (or its delegate) will notify the Participant of the failure as soon as possible, but not later than 5 days following the failure and of the proper procedures to be followed in filing a claim for benefits. Notification may be oral, unless written notification is requested by the Participant or authorized representative. This paragraph (A) applies only to a communication by a Participant or an authorized representative that is received by a person or organizational unit customarily responsible for handling benefit matters; and that names a specific Participant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

The Plan Administrator will notify the Participant of the Plan's determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Participant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Participant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(C) Post-Service Claims. A post-service claim is any claim for a benefit under the plan that is not a pre-service claim. In the case of a post-service claim, the Plan Administrator will notify the Participant of the Plan's adverse benefit determination within a reasonable period of time, but no later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Participant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Participant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(D) Concurrent Care Claims. If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments will constitute an adverse benefit determination. The Plan Administrator will notify the Participant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

Any request by a Participant to extend the course of treatment beyond the period of time or number of treatments that is an urgent care claim will be decided as soon as possible, taking into account the medical exigencies, and the Plan Administrator will notify the Participant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Notwithstanding anything herein to the contrary, the timeframe for benefit determinations under group health plans will be determined as provided under DOL Reg. section 2560.503-1(f)(2). For purposes of this Section 5.01, group health plan means a group health plan as defined in DOL Reg. section 2560.503-1(m)(6).

(iii) Disability Plan Claims (or Claims Involving Disability). Notice of an adverse benefit determination will be provided 45 days after receipt of the claim. This period may be extended by the Plan for up to 30 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. The period for making the determination may be extended for up to an additional 30 days if the Plan Administrator notifies the claimant prior to the expiration of the first 30-day extension period the circumstances of the extension and the date by which the Plan expects to render a decision. Any notice extension under this section shall explain the standards on which the entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

(c) Content of Notice of Denied Claim.

(i) If a claim is wholly or partially denied, the Plan Administrator shall provide the claimant with a written notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, and (4) an explanation of the steps that the claimant must take if he wishes to appeal the denial including a statement that the claimant may bring a civil action under ERISA.

(ii) In addition, if the wholly or partially denied claim is by a Subsidiary Contract providing group health or disability benefits, the following information must also be included in the written notice: (1) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or (2) if the adverse benefit determination is based on a medical

necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(iii) In the case of a wholly or partially denied claim involving urgent care (as defined in DOL Reg. section 2560.503-1(m)(1)) under a Subsidiary Contract providing group health benefits, the notice must include a description of the expedited review process applicable to such claims. In addition, the information described in this Section 5.01(c) may be provided orally within the timeframe required under Section 5.01(b) provided that a written or electronic notification is furnished to the claimant not later than 3 days after the oral notification.

(d) Appeal of Denied Claim.

(i) If a claimant wishes to appeal the denial of a claim, he shall file a written appeal with the Plan Administrator on or before the 60th day after he receives the Plan Administrator's written notice that the claim has been wholly or partially denied (the 180th day for claims involving a group health plan or disability benefits). The written appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The claimant shall lose the right to appeal if the appeal is not timely made.

The claimant shall be provided, upon request and free of charge, documents and other information relevant to his claim. A written appeal may also include any comments, statements or documents that the claimant may desire to provide. The Plan Administrator shall consider the merits of the claimant's written presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. If the claim is under a Subsidiary Contract providing group health or disability benefits, the claims procedures shall be determined in accordance with DOL Reg. section 2560.503-1(h)(3) and 2560.503-1(h)(4).

(ii) If the claim is for group health plan or disability plan benefits, the following will apply:

(A) The review will not afford deference to the initial adverse benefit determination. The appeal will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor a subordinate of such individual;

(B) In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determination with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary will consult with a health



care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional engaged for purposes of a consultation will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor a subordinate of any such individual;

(C) The Plan will identify the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Participant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(D) In the case of an urgent care claim, the Plan will expedite review of the claim such that a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the Participant and all necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and the Participant by telephone, facsimile, or other available similarly expeditious method.

(iii) The Plan Administrator shall ordinarily rule on an appeal within 60 days. However, if special circumstances require an extension and the Plan Administrator furnishes the claimant with a written extension notice during the initial period, the Plan Administrator may take up to 120 days to rule on an appeal. If the denied claim is by a Subsidiary Contract providing group health or disability benefits, the timing of the Plan Administrator's review shall be determined in accordance with DOL Reg. section 2560.503-1(i)(2) and 560.503-1(i)(3).

If a committee is designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, the committee will instead make a benefit determination no later than the date of the meeting of the committee that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination will be rendered not later than the third meeting of the committee following the Plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Plan Administrator will provide the Participant with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Plan Administrator will notify the Participant of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

(e) Denial of Appeal. If an appeal is wholly or partially denied, the Plan Administrator shall provide the claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and

copies of, all documents, records, and other information relevant to the claimant's claim for benefits, and (4) a statement describing the claimant's right to bring an action under section 502(a) of ERISA. The determination rendered by the Plan Administrator shall be binding upon all parties. In addition, if the claim is under a Subsidiary Contract providing group health or disability benefits, the denial notice shall include additional information required under DOL Reg. section 2560.503-1(j)(5).

(f) Exhaustion of Remedies. Before a suit can be filed in federal court, claims must exhaust internal remedies.

(g) Additional Claims Processes.

(i) Applicability. This Subsection shall apply to the extent (1) the Plan constitutes a group health plan as defined in Treas. Reg. section 54.9801-2 or if the Plan Administrator determines that the Plan is subject to HIPAA portability rules and (2) the Plan is not a grandfathered health plan under the Patient Protection and Affordable Care Act.

(ii) Effective Date. This Subsection shall be effective the later of the first plan year beginning after September 23, 2010 or the date the Plan is no longer a grandfathered health plan under the Patient Protection and Affordable Care Act.

(iii) Internal Claims Process. The claims requirements above shall apply as the internal claims process except as provided under DOL Reg. 2590.715-2719 and any superseding guidance.

(A) Adverse Benefit Determination. An adverse benefit determination means an adverse benefit determination as defined in DOL Reg. 2560.503-1, as well as any rescission of coverage, as described in DOL Reg. 2590.715-2712(a)(2).

(B) Expedited Urgent Care Determinations. The requirements of DOL Reg. section 2560.503-1(f)(2)(i) apply as provided in DOL Reg. 2590.715-2719(b)(2)(ii)(B) and any superseding guidance. Claimants must be notified of benefit determinations (whether adverse or not) with respect to a claim involving urgent care (as defined in DOL Reg. section 2560.503-1(m)(1)) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the receipt of the claim.

(C) Full and Fair Review. A claimant must be allowed to review the file and present evidence and testimony as part of the internal appeals process. Claimants must be provided, free of charge, with any new or additional evidence considered relied upon or generated by the Plan in connection with the claim sufficiently in advance of the final adverse benefit determination to give the claimant a reasonable opportunity to respond prior to that date. The Plan must also meet the conflict of interest requirements under DOL Reg. 2590.715-2712(b)(2)(D).

(D) Notice. A description of available internal and external claims processes and information regarding how to initiate an appeal must be provided. Notices of adverse benefit determinations must include the information required under DOL Reg. 2590.715-2719(b)(2)(ii)(E) as applicable. The final notice of internal adverse benefit determination must include a discussion of the decision. Notice must be provided in a linguistically appropriate manner as provided under DOL Reg. 2590.715-2719(e). The Plan must disclose the contact information for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

(E) Deemed Exhaustion of Internal Claims Process. If the Plan fails to adhere to the requirements of DOL Reg. 2590.715-2719(b)(2), except as provided under DOL Reg. 2590.715-2719(b)(2)(ii)(F)(2), the claimant may initiate an external review under Section 6.02(b)(2) or may bring an action under section 502(a) of ERISA as provided in DOL Reg. 2590.715-2719(b)(2)(ii)(F) and any superseding guidance.

(iv) External Claims Process.

(A) State Process. To the extent the Plan is required under DOL Reg. section 2590.715-2719(c)(1)(i) or (c)(1)(ii) to comply with a State external claims process that includes at a minimum the consumer protections in the NAIC Uniform Model Act, then the plan or issuer must comply with the state external claims process of DOL Reg. section 2590.715-2719(c).

(B) Federal Process. To the extent the Plan is not required under DOL Reg. section 2590.715-2719(c)(1)(i) or (c)(1)(ii) to comply with the State external claims process, then the plan or issuer must comply with the Federal external claims process of DOL Reg. section 2590.715-2719(d) and any superseding guidance.

(h) Legal Action. Any legal action by a Participant or beneficiary cannot be brought more than one year after the final determination of the claim under the Plan's claims rules.

#### Section 5.02 MINOR OR LEGALLY INCOMPETENT PAYEE

If a distribution is to be made to an individual who is either a minor or legally incompetent, the Plan Administrator may direct that such distribution be paid to the legal guardian. If a distribution is to be made to a minor and there is no legal guardian, payment may be made to a parent of such minor or a responsible adult with whom the minor maintains his residence, or to the custodian for such minor under the Uniform Transfer to Minors Act, if such is permitted by the laws of the state in which such minor resides. Such payment shall fully discharge the Plan Administrator and the Employer from further liability on account thereof.

**Section 5.03** **MISSING PAYEE**

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participants or other person after reasonable efforts have been made to identify or locate such person, such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited one year after the date any such payment first became due.

**ARTICLE 6**  
**AMENDMENT OR TERMINATION OF PLAN**

**Section 6.01** **AMENDMENT**

The Plan Sponsor has the right to amend the provisions of the Plan, including any list of Subsidiary Contracts and component benefit plans, in writing at any time and from time to time.

**Section 6.02** **TERMINATION**

(a) It is the intention of the Plan Sponsor that this Plan will be permanent. However, the Plan Sponsor reserves the right to terminate the Plan at any time for any reason.

(b) Each entity constituting the Employer reserves the right to terminate its participation in this Plan. In addition, each such entity constituting the Employer shall be deemed to terminate its participation in the Plan if: (i) it is a party to a merger in which it is not the surviving entity and the surviving entity is not an affiliate of another entity constituting the Employer, or (ii) it sells all or substantially all of its assets to an entity that is not an affiliate of another entity constituting the Employer.

(c) Upon termination, any assets remaining in the Plan shall be used to pay outstanding benefit claims. To the extent permitted by the Subsidiary Contracts and to the extent the assets do not revert to the Employer, any remaining assets shall be refunded to Participants.

## **ARTICLE 7 GENERAL PROVISIONS**

### **Section 7.01 NONALIENATION OF BENEFITS**

No Participant or Beneficiary shall have the right to alienate, anticipate, commute, pledge, encumber or assign any of the benefits, payments, or rights to legal action, which he may expect to receive, contingently or otherwise, under the Plan.

### **Section 7.02 NO RIGHT TO EMPLOYMENT**

Nothing contained in this Plan shall be construed as a contract of employment between the Employer and the Participant, or as a right of any employee to continue in the employment of the Employer, or as a limitation of the right of the Employer to discharge any of its employees, with or without cause.

### **Section 7.03 GOVERNING LAW**

(a) The Plan shall be construed in accordance with and governed by the laws of the state or commonwealth of organization of the Plan Sponsor to the extent not preempted by Federal law.

(b) The Plan hereby incorporates by reference any provisions required by state law to the extent not preempted by Federal law.

### **Section 7.04 TAX EFFECT**

The Employer does not represent or guarantee that any pre-tax premiums or benefits made to or on behalf of the Participant will be treated as nontaxable for any particular federal, state or local income, payroll, or personal property tax, or that any other tax consequence will result from participation in this Plan. If it is determined that an amount paid as a benefit is includable in the Participant's gross income for income tax purposes, under no circumstances will the Participant nor any other covered person have any recourse against the Employer, the Plan Administrator or any Adopting Employer with respect to any increased taxes or any other losses or damages suffered by the Participant as a result. A Participant should consult with professional tax advisors to determine the tax consequences of his or her participation.

### **Section 7.05 SEVERABILITY OF PROVISIONS**

If any provision of the Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provisions hereof, and the Plan shall be construed and enforced as if such provisions had not been included.

**Section 7.06 HEADINGS AND CAPTIONS**

The headings and captions herein are provided for reference and convenience only, shall not be considered part of the Plan, and shall not be employed in the construction of the Plan.

**Section 7.07 GENDER AND NUMBER**

Except where otherwise clearly indicated by context, the masculine and the neuter shall include the feminine and the neuter, the singular shall include the plural, and vice-versa.

**Section 7.08 EFFECT OF MISTAKE**

In the event of a mistake as to the eligibility or participation of an employee, or the allocations made to the account of any Participant, or the amount of distributions made or to be made to a Participant or other person, the Plan Administrator shall, to the extent it deems possible, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as will in its judgment accord to such Participant or other person the credits to the account or distributions to which he is properly entitled under the Plan. Such action by the Administrator may include withholding of any amounts due the Plan or the Employer from compensation paid by the Employer.

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## ARTICLE 8 HIPAA

The Plan will comply with the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA") as set forth below.

### Section 8.01 HIPAA PRIVACY COMPLIANCE

The Plan's HIPAA privacy compliance rules ("Privacy Rule") are as follows:

(a) Permitted Use or Disclosure of PHI by Plan Sponsor. Any disclosure to and use by the Plan Sponsor of any PHI will be subject to and consistent with this Section.

(1) The Plan and health insurance issuer, HMO, or Business Associate servicing the Plan may disclose PHI to the Plan Sponsor to permit the Plan Sponsor to carry out Plan Administration Functions, including but not limited to the following purposes:

(A) to provide and conduct Plan Administrative Functions related to payment and health care operations for and on behalf of the Plan;

(B) for auditing claims payments made by the Plan;

(C) to request proposals for services to be provided to or on behalf of the Plan; and

(D) to investigate fraud or other unlawful acts related to the Plan and committed or reasonably suspected of having been committed by a Plan Participant.

(2) The uses described above in (1) are permissible only if the Notice of Privacy Practices distributed to covered Individuals in accordance with the Privacy Rule states that PHI may be disclosed to the Plan Sponsor.

(3) The Plan or a health insurance issuer or HMO may disclose to the Plan Sponsor information regarding whether an Individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

(b) Restrictions on Plan Sponsor's Use and Disclosure of PHI.

(1) The Plan Sponsor will not use or further disclose PHI, except as permitted or required by the Plan or as required by law.

(2) The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides PHI agrees to the restrictions and conditions of this Section.



(3) The Plan Sponsor will not, and will not permit a health insurance issuer or HMO to, use or disclose PHI for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

(4) The Plan Sponsor will report to the Plan any use or disclosure of PHI that is inconsistent with the uses and disclosures allowed under this Section promptly upon learning of such inconsistent use or disclosure.

(5) The Plan Sponsor will make a covered Individual's PHI available to the covered Individual in accordance with the Privacy Rule.

(6) The Plan Sponsor will make PHI available for amendment and will, upon notice, amend PHI in accordance with the Privacy Rule.

(7) The Plan Sponsor will track certain PHI disclosures it makes so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with the Privacy Rule.

(8) The Plan Sponsor will make its internal practices, books, and records, relating to its use and disclosure of PHI received from the Plan to the Secretary of the U.S. Department of Health and Human Services to determine the Plan's compliance with the Privacy Rule.

(9) The Plan Sponsor will, if feasible, return or destroy all PHI, in whatever form or medium (including in any electronic medium under the Plan Sponsor's custody or control) received from the Plan, including all copies of and any data or compilations derived from and allowing identification of any Individual who is the subject of the PHI, when that PHI is no longer needed for the Plan Administration Functions for which the disclosure was made. If it is not feasible to return or destroy all such PHI, the Plan Sponsor will limit the use or disclosure of any PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

(10) When using or disclosing PHI, or when requesting PHI from another party, the Plan sponsor must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure, and limit any request for PHI to the minimum necessary to satisfy the purpose of the request.

(11) The Plan Sponsor will not use any genetic information for any underwriting purposes.

(c) Adequate Separation between the Plan Sponsor and the Plan.

(1) Only those employees of the Plan Sponsor, as outlined in the Plan's HIPAA Policies and Procedures, may be given access to PHI received from the Plan or a health insurance issuer, HMO or Business Associate servicing the Plan.

(2) The members of the classes of employees identified in the Plan's HIPAA Policies and Procedures will have access to PHI only to perform the Plan Administration Functions that the Plan Sponsor provides for the Plan.

(3) The Plan Sponsor will promptly report to the Plan any use or disclosure of PHI in breach, violation of, or noncompliance with, the provisions of this Section of the Plan, as required under this Section, and will cooperate with the Plan to correct the breach, violation or noncompliance, will impose appropriate disciplinary action or sanctions, including termination of employment, on each employee who is responsible for the breach, violation or noncompliance, and will mitigate any deleterious effect of the breach, violation or noncompliance on any Individual covered under the Plan, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance. Regardless of whether a person is disciplined or terminated pursuant to this section, the Plan reserves the right to direct that the Plan Sponsor, and upon receipt of such direction the Plan Sponsor shall, modify or revoke any person's access to or use of PHI.

(d) Purpose of Disclosure of Summary Health Information to Plan Sponsor.

(1) The Plan and any health insurance issuer or HMO may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of obtaining premium bids from health plans for providing health insurance coverage under the Plan.

(2) The Plan and any health insurance issuer or HMO may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan.

(e) Plan Sponsor Certification. The Plan Sponsor will provide the Plan with a certification stating that the Plan has been amended to incorporate the terms of this Article and that the Plan Sponsor agrees to abide by these terms. The Plan Sponsor will also provide the certification upon request to its health insurance issuers, HMOs and Business Associates of the Plan.

(f) Rights of Individuals.

(1) Notice of Privacy Practices. The Plan Sponsor will provide a Notice of Privacy Practices to the Participant in accordance with HIPAA.

(2) Right to Request Restrictions. Each Individual has the right to request that the Plan restrict its uses and disclosures of the Individual's PHI.

(3) Right to Access. Each Individual has the right to obtain and inspect its PHI held by the Plan.

(4) Right to Amend. Each Individual has the right to ask the Plan to amend its PHI.

(5) Right to an Accounting. Each Individual has the right to request an accounting of disclosures of PHI made by the Plan for purposes other than treatment, payment or health care operations.

#### Section 8.02 HIPAA SECURITY COMPLIANCE

To ensure the Plan's compliance with HIPAA's privacy compliance rules ("Security Rule"), the Plan Sponsor will:

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

(b) Ensure that the adequate separation required by the HIPAA Security Rule is supported by reasonable and appropriate security measures;

(c) Ensure that any agent, including a subcontractor, to whom it provides this information, agrees to implement reasonable and appropriate security measures to protect the information; and

(d) Report to the Plan any security incident of which it becomes aware.

#### Section 8.03 HIPAA COMPLIANCE FOR FULLY INSURED GROUP HEALTH BENEFITS

Notwithstanding the foregoing, to the extent any of the Plan's group health benefits are fully insured, the Plan Sponsor has adopted a policy of not receiving, disclosing or using PHI or Summary Health Information regarding insured benefits for any purpose permitted under HIPAA, unless authorized by the Individual, when appropriate.

**APPENDIX A**  
**WELFARE BENEFIT PLANS**

The following welfare benefits of the Plan Sponsor are subject to ERISA and are covered by the Plan:

<b>WELFARE BENEFIT</b>	<b>FUNDING TYPE</b>
Medical	Fully-insured
Dental	Fully-insured
Vision	Fully-insured
Group Life	Fully-insured
Accidental Death & Dismemberment	Fully-insured
Short-Term Disability	Fully-insured
Long-Term Disability	Fully-insured
Specified Voluntary Worksite Plans	Fully-insured
Health Flexible Spending Account (FSA)	Self-insured

The Plan Sponsor has adopted this Plan as of this date:

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**Tampa Bay Workforce Alliance, Inc. DBA CareerSource Tampa Bay:**

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Title/Position: \_\_\_\_\_

# CareerSource Tampa Bay Employee Health & Welfare Plan

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WRAP

## SUMMARY PLAN DESCRIPTION

ERISA PLAN NUMBER 501

September 1, 2018

Prepared by



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CareerSource Tampa Bay  
Employee Health & Welfare Plan  
Summary Plan Description

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## **INTRODUCTION**

Tampa Bay Workforce Alliance, Inc. DBA CareerSource Tampa Bay (the "Employer") established the CareerSource Tampa Bay Employee Health & Welfare Plan (the "Plan") effective January 1, 2018. This Summary Plan Description describes the Plan as amended and restated effective September 1, 2018.

This revised Summary Plan Description supersedes all previous Summary Plan Descriptions. Although the purpose of this document is to summarize the more significant provisions of the Plan, the Plan document will prevail in the event of any inconsistency.

## **OTHER SUMMARY PLAN DESCRIPTIONS**

This Plan incorporates the terms of all Welfare Benefit Plans listed in Appendix A in addition to the terms of all Welfare Benefit Plans subject to ERISA sponsored by the Employer or any Affiliated Employer who has adopted the Plan (contact your Plan Administrator if you are unsure which welfare benefits plans are subject to ERISA).

You will receive separate Summary Plan Descriptions and/or certificates of coverage from each of the Welfare Benefit Plans that are component parts of this Plan. In the separate Summary Plan Descriptions and/or certificates of coverage you will find information about eligibility, benefits, and employee/employer contributions for each of the separate Welfare Benefit Plans. You are eligible to participate in this Plan if you are eligible to participate in one of the Welfare Benefit Plans that are component parts of this Plan. In addition, in general, all benefits of this Plan are provided by the Welfare Benefit Plans that are component parts of this Plan.

This Summary Plan Description incorporates the terms of the other Summary Plan Descriptions and/or certificates of coverage for each of the Welfare Benefit Plans that are component parts of this Plan.

If applicable, the Employer will pay its contributions/premiums and any employee contributions to the insurance carriers as required for each such coverage. Employee contributions toward the cost of a particular benefit will be used in their entirety prior to using the Employer's contributions to pay for the cost of such benefit. The Employer's contributions to the Welfare Benefit Plans that are component parts of this Plan shall be made from the general assets of the Employer and on a basis consistent with any regulations that govern such programs and policies. For certain benefit programs, employees may make pre-tax salary reduction elections to pay for benefits through an employer-provided cafeteria plan, if available. For more information, refer to the cafeteria plan governing document. For more information related to contribution shares, refer to subsidiary contract documents or benefit booklets, if available.

## ADMINISTRATIVE INFORMATION

1. The Plan Sponsor and Plan Administrator is Tampa Bay Workforce Alliance, Inc. DBA CareerSource Tampa Bay.  
  
Its address is  
4902 Eisenhower Blvd., Suite 250  
Tampa, Florida 33634  
  
Its telephone number is 813-930-7400.  
  
Its Employer Identification Number is 59-3655316.
2. The Plan is a Welfare Benefit Plan which has been designated by the sponsor as its plan number is 501.
3. The Employer's fiscal year ends on June 30 and the Plan Year ends on December 31.
4. While the Plan Administrator has the primary fiduciary duties, insurance companies are also held to fiduciary responsibilities as it relates to the benefits they insure.
5. The Plan's designated agent for service of legal process is the chief officer of the entity named in number 1. Any legal papers should be delivered to him or her at the address listed in number 1. However, service may also be made upon the Plan Administrator.
6. The Plan allows other employers to adopt its provisions. You or your beneficiaries may examine or obtain a complete list of employers, if any, who have adopted your Plan by making a written request to the Plan Administrator.

## ELIGIBILITY AND ENROLLMENT

### How to Become a Participant in the Plan

Before you become a Participant, you must meet the eligibility requirements for the Plan, work (or be expected to work) the required number of hours per week on average, and satisfy the applicable Waiting Period or other measurement period as described in this section.

## Enrollment

You will become a Participant in this Plan once you have satisfied the requirements and formally elect benefits. If you do not want any or all of the benefits offered under the Plan, you may elect not to receive such benefits in accordance with the procedures established by the Plan Administrator.

## Eligibility for Medical Benefits

The Employer offers coverage to Eligible Employees, their Spouses, and Dependents, including Dependents who have been adopted or placed for adoption with a Participant.

In general, if you regularly work, or are expected to work, 30 hours or more per week on average, and you are not a Seasonal Employee, you will be eligible to become a Participant.

If you were expected to be an Eligible Employee at the time of hire, you may become a Participant following completion of the Waiting Period. If you choose to enroll, participation will begin the first of the month following 30 days after the date of hire.

If you are designated as a Variable Hour Employee at the time of hire, and later become an Eligible Employee, you will be allowed to become a Participant after the Initial Administrative Period. A Seasonal Employee will be treated as a Variable Hour Employee with respect to eligibility.

If you are an Ongoing Employee who becomes an Eligible Employee following the Standard Measurement Period, you will be allowed to become a Participant after the Standard Administrative Period.

## *Measurement, Administrative, and Stability Periods*

In determining eligibility for the group health plan, the Employer intends to follow IRS regulations and any subsequent guidance when administering the measurement, administrative, and stability periods.

If you are a Variable Hour Employee, you must first complete an Initial Measurement Period during which you will not be eligible for coverage. At the end of the Initial Measurement Period, if you are determined to be an Eligible Employee, you will be notified by the Plan Administrator and will be eligible to participate in the group health plan after the Initial Administrative Period. The Employer will use the Initial Administrative Period to determine whether you are eligible and to give you the opportunity to enroll if you are determined to be an Eligible Employee. If you choose to enroll, participation will begin on the first day of the Initial Stability Period.

### *Eligibility When Rehired*

If your employment with the company is terminated and you are later rehired, company policies and complex IRS rules will be used to determine whether you are eligible.

### *Changes that may Affect Eligibility Status*

If your hours of work are reduced, or you move to a different job within the company, your eligibility for benefits may change. Company policies and complex IRS rules will be used to determine whether you are eligible.

### Eligibility for Other Benefits

Unless otherwise here stated, the eligibility requirements of each separate welfare benefit can be found in the applicable Summary Plan Descriptions and/or certificates of coverage. If the eligibility terms stated above differ from the applicable Summary Plan Descriptions and/or certificates of coverage, the terms stated above will apply.

## **CLAIMS**

### Refunds/Indemnification

You must immediately repay any excess payments/reimbursements. You must reimburse the Employer for any liability the Employer may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset your salary or wages, and/or (ii) offset other benefits payable under this Plan.

### Third Party Recovery

If you are paid benefits from any other plan or policy, the Plan may be entitled to reimbursement. In particular, the Plan may be entitled to reimbursement for benefits which are related to medical expenses that are also payable under workers' compensation, any statute, any uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy or any other plan of benefits, or when related medical expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement or for any other reason.

By participating in the Plan, you and your covered dependents consent and agree that a constructive trust, lien, or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. You and your covered dependents agree to cooperate with the Plan in reimbursing it for Plan costs and expenses. If you or your covered dependents have any reason to believe that the Plan may be entitled to recovery from any third party, you must notify the Plan. And, at that time, you (and your attorney, if applicable) must sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle the Participant or covered dependent to any payment, amount or recovery from a third party.

You and your covered dependents consent and agree that you will not assign your rights to settlement or recovery against a third person or party to any other party, including your attorneys, without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Plan.

### Coordination of Benefits

If you, your spouse, or dependents are covered by more than one health plan (referred to as an "Arrangement"), detailed rules will be used to determine which Arrangement pays or provides benefits first. If applicable, a secondary Arrangement may reduce the benefits it pays so that payments from all Arrangements do not exceed 100% of the total allowable amount. The rules for coordination of benefits are further explained in the Summary Plan Descriptions and other documents governing the Arrangements.

### Medical Loss Rebates

Under the Patient Protection and Affordable Care Act (ACA), the law requires insurers to issue Medical Loss Ratio (MLR) rebates in certain circumstances. MLR rebates are based upon aggregated market data in each state and not upon a particular group health plan's experience. The portion of the rebate attributable to Participant contributions may be distributed to you, applied towards future premiums, or held in trust for the benefit of Plan Participants. This section applies only for fully insured medical plans.

### Claim Procedures - In General

This section applies for any claim for benefits under a Welfare Benefit Plan that is covered by ERISA unless the Welfare Benefit Plan has a claims procedure that is compliant with ERISA section 503. If the Welfare Benefit Plan has a claims procedure that is compliant with ERISA section 503, the claims procedure of the Welfare Benefit Plan will apply. In general, this means that if the claims procedure of the Welfare Benefit Plan has timeframes and procedures that are at least as favorable to you or more favorable than the deadlines provided below, the claims procedure of the Welfare Benefit Plan will apply. In the case of a group health plan, any procedures for obtaining prior approval as a prerequisite for obtaining a benefit, such as preauthorization procedures or utilization review procedures are described in the relevant SPD for that plan and incorporated herein.

You or any other person entitled to benefits from the Welfare Benefit Plan (a "claimant") may apply for such benefits by completing and filing a claim with the applicable Welfare Benefit Plan provider in accordance with the provider's claim filing guidelines. In general, claims must be filed in writing (except urgent care claims, which may be made orally) with the applicable Welfare Benefit Plan provider. Any claim that does not relate to a specific benefit under the plan (for example, a general eligibility claim or a dispute involving a mid-year election change) must be filed with the Welfare Benefit Plan's Plan Administrator. Any claim must include all information and evidence that the Welfare Benefit Plan provider or plan administrator (the "Claim Reviewer") deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. If a claim is received, but there is

not enough information to process the claim, you will be given an opportunity to provide the missing information.

A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined that your inquiry is an attempt to file a claim.

If you want to bring a claim for benefits under the Plan, you may designate an authorized representative to act on your behalf so long as you provide written notice of such designation to the applicable provider identifying such authorized representative. In the case of a claim for medical benefits involving urgent care, a health care professional who has knowledge of your medical condition may act as your authorized representative with or without prior notice.

#### Timing of Notice of Claim

The Claim Reviewer will notify the claimant of any benefit determination within a reasonable period of time but not later than the timeframe specified below depending on the type of claim.

#### *Group Health Plan Claims*

Group health plan claims may involve urgent care, concurrent care claims, pre-service care claims or post-service claims. Each has different time-frames that may apply and is described below.

**Urgent Care.** The Claim Reviewer will notify the claimant of the benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable. In the case of such a failure, the Claim Reviewer will notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. This notification may be made orally, unless you request written notification. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Claim Reviewer will notify the claimant of the determination as soon as possible, but in no case later than 48 hours after the earlier of (A) the plan's receipt of the specified information, or (B) the end of the period afforded the claimant to provide the specified additional information.

**Concurrent care** (a group health plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments). The Welfare Benefit Plan will notify a claimant of any reduction or termination of a course of treatment (other than by plan

amendment or termination) before the end of such period of time or number of treatments at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care that will be decided as soon as possible, taking into account the medical exigencies, and the Claim Reviewer will notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the plan, provided that any such claim is made to the plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Pre-service claims. The Claim Reviewer will notify the claimant of the plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the plan. This period may be extended one time by the plan for up to 15 days, provided that the Claim Reviewer both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Claim Reviewer expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Post-service claims. The Claim Reviewer will notify the claimant, of an adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the plan for up to 15 days, provided that the Claim Reviewer both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

### *Disability Claims*

In the case of a claim for disability benefits, the Claim Reviewer will notify the claimant, of the plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the plan. This period may be extended by the plan for up to 30 days, provided that the Claim Reviewer both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If, prior to the end of the first 30-day extension period, the administrator determines that, due to matters beyond the control of the



Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Claim Reviewer notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision. The notice of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant will be afforded at least 45 days within which to provide the specified information.

#### *Other Claims*

The Claim Reviewer will notify the claimant of any adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim. This period may be extended one time by the Plan for up to 90 days, provided that the Claim Reviewer both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial review period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

#### Content of Notice of Denied Claim

If a claim is wholly or partially denied, the Claim Reviewer will provide the claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (4) an explanation of the steps that the claimant must take if he wishes to appeal the denial including a statement that the claimant may bring a civil action under ERISA.

In addition to the above information, if it is a group health plan or a plan providing disability benefits, the following information must be included with the notice described above:

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

If the denied claim is for a disability benefit under the Plan, the following information will also be included in the written notice:

1. A discussion of the decision, including an explanation of the basis for disagreeing with or not following (a) the views presented by health care professionals treating the covered person and vocational professionals who evaluated the covered person; (b) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (c) a disability determination made by the Social Security Administration and presented to the Plan.

2. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or a statement that such explanation will be provided free of charge upon request.

3. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist.

4. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for disability benefits.

In addition, in the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims must be included with the notice described above and may be provided to the claimant orally within the time frame described above, provided that a written or electronic notification is furnished to the claimant not later than 3 days after the oral notification.

#### Appeal of Denied Claim

If a claimant wishes to appeal the denial of a claim, he must file an appeal with the Claim Reviewer on or before the 180th day (or the 60th day in the case of a claim other than a group health plan benefit or a disability benefit) after he receives the Claim Reviewer's notice that the claim has been wholly or partially denied. The appeal will identify both the grounds and specific Plan provisions upon which the appeal is based. The claimant will be provided, upon request and free of charge, documents and other information relevant to his claim. An appeal may also include any comments, statements or documents that the claimant may desire

to provide. The Claim Reviewer will consider the merits of the claimant's presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Claim Reviewer may deem relevant. The claimant will lose the right to appeal if the appeal is not timely made.

In considering the appeal of a group health plan benefit or a disability benefit, the Claim Reviewer will:

1. Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

2. Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

3. Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

4. Provide that the health care professional engaged for purposes of a consultation under Subsection (2) will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

5. In addition, in the case of a claim involving urgent care, provide for an expedited review process pursuant to which (A) a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and (B) all necessary information, including the plan's benefit determination on review, will be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

If the claim is for disability benefits under the Plan, the following will apply:

1. Before the Plan issues any adverse benefit determination, the Claim Reviewer will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination (or at the direction of the Plan) in connection with the claim, and any new or

additional rationale must be provided to you as soon as possible and sufficiently in advance of the date on which the Plan must provide you with the notice of final adverse benefit determination so that you have a reasonable opportunity to respond prior to that date.

2. If the determination is based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse benefit determination is required to be provided to give you a reasonable opportunity to respond prior to that date. If the new or additional evidence is received so late that it would be impossible to provide it in time for you to have a reasonable opportunity to respond, the Plan's deadline for providing a notice of final adverse benefit determination will be delayed until you have had a reasonable opportunity to respond. After you respond, or had a reasonable opportunity to respond but failed to do so, the Claim Reviewer will notify you of the Plan's benefit determination as soon as a plan acting in a reasonable and prompt fashion can provide the notice, taking into account the urgency of the medical situation.

#### Notice of Denied Appeal Review

If a claim is wholly or partially denied, the Claim Reviewer will provide the claimant with a notice identifying all the information identified above, plus a discussion of the decision and available external claims processes and information regarding how to initiate an appeal.

Except as provided below for group health urgent care, pre-service and post-service claims, the Claim Reviewer will notify the claimant of the Plan's benefit determination on review within 60 days after receipt by the Plan of the claimant's request for review of an adverse benefit determination (45 days in the case of a claim involving disability benefits). If the Claim Reviewer determines that an extension of time for processing is required, written notice of the extension will be furnished to the claimant prior to the termination of the initial 60-day period (45 days in the case of a claim involving disability benefits). In no event will such extension exceed a period of 60 days from the end of the initial period (45 days in the case of a claim involving disability benefits). The extension notice will indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the determination on review.

Urgent care claims. In the case of a claim involving urgent care, the Claim Reviewer will notify the claimant of the plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination by the plan.

Pre-service claims. In the case of a pre-service claim, the Claim Reviewer will notify the claimant, of the plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such notification will be provided not later than 30

days after receipt by the plan of the claimant's request for review of an adverse benefit determination.

Post-service claims. The Claim Reviewer will notify the claimant of the plan's benefit determination on review within a reasonable period of time. Such notification will be provided not later than 60 days after receipt by the plan of the claimant's request for review of an adverse benefit determination.

If an appeal is wholly or partially denied, the Plan Administrator will provide you with a notice identifying (1) the reason or reasons for such denial; (2) the Plan provisions on which the denial is based; (3) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and (4) a statement describing your right to bring an action under section 502(a) of ERISA. The determination rendered by the Plan Administrator will be binding upon all parties.

In the case of a group health plan or a plan providing disability benefits, the notice will also include:

1. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request;

2. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

3. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

In the case of a claim involving disability benefits, the notice will also include:

1. Any applicable contractual limitations period that applies to your right to bring an action under section 502(a) of ERISA, including the calendar date that the contractual limitations period expires for the claim.

2. A discussion of the decision, including an explanation of the basis for disagreeing with or not following (a) the views presented by health care professionals treating the covered person and vocational professionals who evaluated the covered person; (b) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (c) a disability determination made by the Social Security Administration and presented to the Plan.

3. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or a statement that such explanation will be provided free of charge upon request.

4. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist.

You must exhaust all internal remedies before you may file a claim or lawsuit in court.

#### Legal Action with Respect to Denied Claims

You have the right to bring a legal action against the Plan for benefits you believe are otherwise due to you. Any legal action cannot be brought until you have exhausted your appeal rights under the Plan. In addition, any legal action cannot be brought more than one year after the final determination of your claim under the Plan's claims rules.

## CONTINUATION RIGHTS

### Military Service

If you serve in the United States Armed Forces and must miss work as a result of such service, you may be eligible to continue to receive benefits with respect to any qualified military service.

### COBRA

Under Federal law, you, your spouse, and your dependents may be entitled to COBRA continuation coverage in certain circumstances. Please see the "COBRA NOTICE" that is attached to the end of this Summary Plan Description for important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The COBRA NOTICE generally explains COBRA continuation coverage and when it may become available to you. The Plan Administrator will inform you of these rights, if any, when you terminate employment.

### FMLA

If your Employer is subject to FMLA, you may qualify to take up to 12 weeks of FMLA leave in a 12 month period each year for any of the following reasons:

- for the birth of your child and to bond with the newborn child within one year of birth;
- for placement of a child for adoption or foster care in your home and to bond with the newly placed child within one year of placement;
- to care for an immediate family member (spouse, child, or parent) with a serious health condition;
- to take medical leave when you are unable to work because of a serious health condition; or
- for any qualifying exigency arising out the fact that a spouse, son, daughter, or parent is a military member on covered active duty or call to covered active duty status.

You may also qualify to take up to 26 weeks of FMLA leave in a single 12 month period:

- to care for a covered servicemember with a serious injury or illness if the employee is the spouse, child, parent or next of kin of the servicemember (military caregiver leave).

You are eligible for leave if you have worked for your Employer at least 12 months, at least 1,250 hours over the past 12 months, and work at a location where your Employer (or Division) employs 50 or more employees within 75 miles. If your division employs less than 50 employees within the 75-mile radius, you may not be eligible for medical leave.

Time taken off work due to pregnancy complications can be counted against the 12 weeks of family and medical leave.

COBRA continuation coverage is available upon the expiration of the 12-week period of FMLA leave, if desired. If you fail to return to active employment following the expiration of the 12-week FMLA period, you will be eligible for COBRA coverage up to 18-months starting from the date of your qualifying event (termination of employment or reduction of hours worked).

Your Employer will establish a payment method, should you wish to continue coverage while on FMLA leave, as prescribed for all such FMLA events which will be consistent with every new request for leave.

### **YOUR RIGHTS UNDER ERISA**

As a Participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). This federal law provides that you have the right to:

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, 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 collective bargaining agreements, and copies of the latest annual report (Form 5500 Series, if the Plan was required by law to file such form), and updated summary plan description. The Plan 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 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.

In addition, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the 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 your benefits or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them 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 Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of 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, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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

## MISCELLANEOUS

### Qualified Medical Child Support Orders

In certain circumstances you may be able to enroll a child in the Plan if the Plan receives a Qualified Medical Child Support Order (QMCSO).

#### **What is a Qualified Medical Child Support Order (QMCSO)?**

A "QMCSO" is a medical child support order (from a court or administrative agency) that creates or recognizes the right of an "alternate recipient" to receive benefits for which a Participant or beneficiary is eligible under a group health plan. It is recognized by the group health plan as "qualified" because it includes information and meets other requirements.

#### **Who can be an "alternate recipient"?**

Any child of a Participant in a group health plan who is recognized under a medical child support order as having a right to enrollment under the plan with respect to such Participant is an alternate recipient.

#### **What information must a medical child support order contain to be a "qualified" order?**

A medical child support order must contain the following information in order to be qualified:

- The name and last known mailing address of the Participant and each alternate recipient, except that the order may substitute the name and mailing address of a State or local official for the mailing address of any alternate recipient;
- A reasonable description of the type of health coverage to be provided to each alternate recipient (or the manner in which such coverage is to be determined);
- The period to which the order applies; and
- An order may not require a plan to provide any type or form of benefit, or any option, not otherwise provided under the plan, except to the extent necessary to meet the requirements of certain State laws.

A "National Medical Support Notice" can also be a qualified medical support notice.

#### **The Plan Administrator has established the QMCSO procedures outlined below.**

Upon receiving a medical child support order the Plan Administrator will:

1. Determine if the document is a National Medical Support Notice or a judgment order or decree from a court or administrative process.
2. Notify the Participant, each alternate recipient and the issuing court or agency in the case of a National Medical Support Notice of the receipt of the order and provide a copy of these procedures.

3. Review the employment status of the affected employee/parent and review the Plan provisions to determine which, if any, group health plan benefits are available to the alternate recipient.
4. Determine if the document is a qualified medical support order.
5. Notify the Participant and the alternate recipient whether the document is a qualified medical support order within a reasonable time after receipt of the order (not to exceed 40 days in the case of a National Medical Support Notice).

#### Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. If you or your dependents become ineligible for Medicaid or a state child health program (CHIP) or become eligible for premium assistance under Medicaid or a state child health program (CHIP), you must request enrollment within 60 days. In addition, 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 dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

#### Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for: all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your Plan Administrator at the number provided at the end of this Summary Plan Description.

#### Newborns' and Mothers' Health Protection

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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

### Mental Health Parity

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”) requires group health plans that provide mental health and substance abuse benefits to cover these services in a manner equal to their coverage of medical and surgical services. For example, separate deductibles may not be applied for treatment of mental health or substance use disorders, as opposed to medical or surgical treatment. The MHPAEA generally applies to employers with more than 50 employees. However, MHPAEA does not apply if your Plan does not currently offer any mental health or substance abuse benefits.

### Loss of Benefit

You may lose all or part of any payment due to you if we cannot locate you when your benefit becomes payable to you.

You may not alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the Plan, except that you may designate a Beneficiary.

### Medicaid

State Medicaid agencies might mistakenly pay claims for which a third party may be liable, because they are not aware of the existence of other coverage. If you are participating in an employer-sponsored health plan for which that health plan is responsible for making benefit payment, and Medicaid has rendered such benefit payment instead for the same service, the state Medicaid agency has the right under an assignment of benefits to recoup such payment from the employer-sponsored health plan.

### Collective Bargaining

If the Plan Sponsor has entered into a collective bargaining agreement that includes welfare benefits offered under this Plan, the collective bargaining agreement may determine certain coverage provisions, including eligibility, employer and employee contribution amounts, types of benefits offered, and other coverage terms for employees who are members of the collective bargaining group.

### Amendment and Termination

The Employer has the right to amend, terminate or merge the Plan at any time, and to change the types of benefits offered from time to time. Any insurers, third party

administrators, or other service providers will be selected by the Employer at its sole discretion.

If the Plan is terminated, any remaining plan assets will be used to pay outstanding benefit claims. Following payment of these claims, remaining assets that are not returned to the Plan Sponsor will be refunded to Participants, if allowed by the terms of the applicable subsidiary contracts.

#### Administrator Discretion

The Plan Administrator has the authority to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan and to supply omissions to the Plan. Any construction, interpretation or application of the Plan by the Plan Administrator is final, conclusive and binding.

#### Taxation

No warranty or any other representation that any pre-tax premiums or benefits made to you or on behalf of you will be treated as nontaxable for local, state or federal income purposes, is made by the Employer or the Plan Administrator. If it is determined that an amount paid as a benefit is includable in your gross income for income tax purposes, under no circumstances will you have any recourse against the Employer, the Plan Administrator or any Adopting Employer with respect to any increased taxes or any other losses or damages suffered by you as a result. You should consult with a professional tax advisor to determine the tax consequences of your participation.

#### Wellness

In general, a wellness plan that offers a reward for participating or satisfying a health-based outcome must not offer a reward that exceeds 30 percent of the total premium for employee-only coverage under the plan. An additional 20 percent can be applied to a wellness program designed to prevent or reduce tobacco use (up to 50 percent of the total premium). If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under the program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under the program, contact the Plan Administrator to discuss another way to qualify for the reward.

If your employer offers a wellness plan, you will receive additional materials describing the operation of the plan, eligibility to participate, and the amount and conditions for any rewards.

This Summary Plan Description incorporates the terms of the additional materials for the wellness plan herein by reference.

### HIPAA Privacy

The Plan is required under federal law to take sufficient steps to protect any individually identifiable health information to the extent that such information must be kept confidential. The Plan Administrator will provide you with more information about the Plan's privacy practices.

Will my health information be kept confidential?

Under HIPAA, group health plans and the third party service providers (where applicable) are required to take steps to ensure that certain "Protected Health Information" is kept confidential.

## NOTICE OF PRIVACY PRACTICES

*This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.*

### Your Rights

*When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.*

#### **Get a copy of health and claims records**

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

#### **Ask us to correct health and claims records**

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

#### **Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

#### **Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

#### **Get a list of those with whom we’ve shared information**

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

### **Get a copy of this privacy notice**

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

### **Choose someone to act for you**

- If you have given someone medical power of attorney, or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

### **File a complaint if you feel your rights are violated**

- If you feel we have violated your rights, you can complain by contacting the Plan Administrator or HIPAA Privacy Officer.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
- We will not retaliate against you for filing a complaint.

### Your Choices

*For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.*

### **In these cases, you have both the right and choice to tell us to:**

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

### **In these cases, we *never* share your information unless you give us written permission:**

- Marketing purposes
- Sale of your information

### Our Uses and Disclosures

### **How do we typically use or share your health information?**

We typically use or share your health information in the following ways:



### **Help manage the health care treatment you receive**

- We can use your health information and share it with professionals who are treating you.
- *Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

### **Run our organization**

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.
- *Example: We use health information about you to develop better services for you.*

### **Pay for your health services**

- We can use and disclose your health information as we pay for your health services.
- *Example: We share information about you with your dental plan to coordinate payment for your dental work.*

### **Administer your plan**

- We may disclose your health information to your health plan sponsor for plan administration.
- *Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

### **How else can we use or share your health information?**

- We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:  
[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

### **Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

### **Do research**

- We can use or share your information for health research.

### **Comply with the law**

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

### **Respond to organ and tissue donation requests and work with a medical examiner or funeral director**

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

### **Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

### **Respond to lawsuits and legal actions**

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

### **Our responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

### **For more information see:**

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

## COBRA NOTICE

### Introduction

This notice applies only to the extent the Employer is subject to COBRA regulations, and to the extent you are participating in certain Employer-sponsored medical benefits (hereafter within this notice referred to as the "Plan").

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

**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.

### What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

### **When is COBRA Continuation Coverage Available?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

The end of employment or reduction of hours of employment; death of the employee; the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notification to the COBRA contact at:

**4902 Eisenhower Blvd., Suite 250  
Tampa, Florida 33634.**

**The Employer's telephone number is 813-930-7400.**

## **How is COBRA Continuation Coverage Provided?**

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

### **Disability extension of 18-month period of COBRA continuation coverage**

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

### **Second qualifying event extension of 18-month period of continuation coverage**

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

### **Are there other coverage options besides COBRA Continuation Coverage?**

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special

enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

### **If You Have Questions**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov).

### **Keep Your Plan Informed of Address Changes**

**To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.**

### **Plan Contact Information**

**Tampa Bay Workforce Alliance, Inc. DBA CareerSource Tampa Bay  
4902 Eisenhower Blvd., Suite 250  
Tampa, Florida 33634  
813-930-7400**

**APPENDIX A**  
**WELFARE BENEFIT PLANS**

The following welfare benefits of the Plan Sponsor are subject to ERISA and are covered by the Plan:

<b>WELFARE BENEFIT</b>	<b>FUNDING TYPE</b>
Medical	Fully-insured
Dental	Fully-insured
Vision	Fully-insured
Group Life	Fully-insured
Accidental Death & Dismemberment	Fully-insured
Short-Term Disability	Fully-insured
Long-Term Disability	Fully-insured
Specified Voluntary Worksite Plans	Fully-insured
Health Flexible Spending Account (FSA)	Self-insured

## GLOSSARY

<b>"Affiliated Employer"</b>	means a related company which adopts the Plan and participates in one or more of the benefits offered under the Plan.
<b>"COBRA"</b>	means the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986, which gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events.
<b>"Dependent"</b>	means any person who qualifies as a dependent under a subsidiary contract for purposes of that contract.
<b>"Eligible Employee"</b>	Is an employee who meets the eligibility requirements for one or more of the benefits offered under this Plan.
<b>"Employer"</b>	means the company sponsoring the Plan and any related companies which participate in one or more of the benefits offered under the Plan.
<b>"ERISA"</b>	means the Employee Retirement Income Security Act of 1974.
<b>"FMLA"</b>	means the Family Medical Leave Act of 1993.
<b>"HIPAA"</b>	means the Health Insurance Portability and Accountability Act of 1996.
<b>"Initial Administrative Period"</b>	means the time during which new Variable Hour Employees who have completed the Initial Measurement Period and have been determined to be Eligible Employees can enroll in or waive medical coverage. This period may not last longer than ninety (90) days and may include a partial month prior to the beginning of the Initial Measurement Period. The Initial Administrative Period, or its second part, begins the next day after the end of the Initial Measurement Period.
<b>"Initial Measurement Period"</b>	means the period of time during which a new Variable Hour Employee's hours of service are measured to determine whether the employee will become an Eligible Employee.
<b>"Initial Stability Period"</b>	means the minimum period of time during which medical coverage must be offered to an employee who was previously a Variable Hour Employee and has been determined to be an Eligible Employee. The Initial Stability Period may not be shorter in duration than the Initial Measurement Period.



<b>"Ongoing Employee"</b>	means an employee who was employed with the Employer on the first day of a Standard Measurement Period.
<b>"Participant"</b>	means an employee who participates in benefits that are offered under this Plan.
<b>"PHI"</b>	means Protected Health Information as defined under HIPAA.
<b>"Plan"</b>	means the benefit programs that are described in this document.
<b>"Plan Year"</b>	means each 12-consecutive month period ending on: <b><u>December 31</u></b> .
<b>"Seasonal Employee"</b>	means an employee who is hired for a position for which the customary annual employment period is six (6) months or less and which begins at approximately the same time of each calendar year. A Seasonal Employee will be treated as a Variable Hour Employee with respect to eligibility.
<b>"Spouse"</b>	means an individual who is lawfully married under any state law or as currently recognized under prevailing Federal law.
<b>"Standard Administrative Period"</b>	means the time during which Ongoing Employees who have completed the Standard Measurement Period can enroll in or disenroll from medical coverage. This period occurs between the Standard Measurement Period and the Standard Stability Period.
<b>"Standard Measurement Period"</b>	means the period during which the Employer counts each Ongoing Employee's hours of service. This period cannot be less than three (3) months nor more than twelve (12) months.
<b>"Standard Stability Period"</b>	means the period of time during which an Ongoing Employee is eligible for medical coverage under the Plan. The Standard Stability Period may not be shorter than the Standard Measurement Period.
<b>"Variable Hour Employee"</b>	means an employee for whom the Employer is not able to determine, at the employee's hire date, whether the employee is reasonably expected to work the required number of hours per week for eligibility.
<b>"Waiting Period"</b>	means the time period during which a newly hired Eligible Employee must be employed by the Employer prior to becoming a Participant.
<b>"Welfare Benefit Plan"</b>	means any plan or program that is offered by the Employer in order to provide ERISA-listed benefits to Eligible Employees, other than pension or retirement programs.

## ERISA ELECTRONIC DISTRIBUTION REQUIREMENTS

### REQUIREMENTS FOR EMPLOYEES WITH WORK-RELATED COMPUTER ACCESS

Definition of work-related computer access: The employee has the capacity to access documents at any workplace location where they reasonably could be expected to perform employment duties. In addition, access to the employer's electronic information system must be a functional part of their employment duties and clearly indicated by the employer.

- ❖ Electronic materials must be prepared and delivered in accordance with otherwise applicable requirements (e.g., timing and format requirements for SPDs as outlined under ERISA.)
- ❖ A notice must be provided to each recipient, at the time that the electronic document is furnished, detailing the significance of the document.
- ❖ The notice must advise the participant of their rights to have the opportunity, at their work site, to access documents furnished electronically and to request and receive (free of charge) paper copies of any documents received electronically.
- ❖ The employer must take appropriate measures to ensure the electronic distribution will result in actual receipt of information by the participants (i.e. return-receipt.)
- ❖ If the disclosure includes personal information relating to an individual's accounts and benefits, the plan must take reasonable and appropriate steps to safeguard the privacy of the information.

### ADDITIONAL REQUIREMENTS FOR NON-EMPLOYEES OR EMPLOYEES WITH NON-WORK RELATED COMPUTER ACCESS

1. Affirmative consent for electronic distribution must be obtained from the individual. Before consent can be obtained, a pre-consent statement must be furnished that explains:
  - ❖ The types of documents that will be provided electronically;
  - ❖ The individual's right to withdraw consent at any time without charge;
  - ❖ The procedures for withdrawing consent and updating information (e.g. updating the address for receiving electronic disclosure);
  - ❖ The right to request a paper version and its cost (if any); and
  - ❖ The hardware and software requirements needed to access the electronic document.
2. The regulations permit the pre-consent statement to be provided electronically if the employer has a current and reliable e-mail address.
3. If system hardware or software requirements change, a revised statement must be provided and renewed consent from each individual must be obtained.
4. If the documents are to be provided via the Internet, the affirmative consent must be given in a manner that reasonably demonstrates the individual's ability to access the information in electronic form, and the individual must have provided an address for the receipt of electronically distributed documents.
5. The Employer must keep track of individual electronic delivery addresses, individual consents and the actual receipt of e-mailed documents by recipients.
6. Steps 1, 2, 4 and 5 outlined above ***under requirements for employees with work-related computer access*** must also be followed.

## SBC Distribution Options

An SBC provided by a plan or insurer to a participant or beneficiary may be provided in paper or electronic format. Unless the plan or insurer has knowledge of a separate address for a beneficiary, the SBC may be provided to the participant on behalf of the beneficiary (including by furnishing the SBC to the participant in electronic form).

### Providing SBC “On Behalf Of” Beneficiaries

As a best practice, plan sponsors relying on this “on behalf of” relief may wish to add appropriate language to enrollment forms and plan procedures to alert participants that an SBC furnished to a participant will also be considered provided to beneficiaries, unless the plan is advised of a different address for a beneficiary.

### Safe Harbor for Online Enrollment

Another safe harbor for electronic delivery of the SBC allows SBCs to be provided electronically to participants and beneficiaries in connection with their online enrollment or renewal of coverage under the plan. **In addition**, an SBC may also be provided electronically to participants and beneficiaries who request an SBC online. In either case, the individual must have the option to receive a paper copy of the SBC upon request. While the guidance does not expand on what it means for the SBC to be provided “in connection with” online enrollment or renewal of coverage, it would seem that providing the SBC at an earlier or later date would not fit within this safe harbor. Also, it appears that the safe harbor would only be satisfied for those actually enrolling online. In other words, it would not be available for those who choose to enroll via another means (e.g., by phone or paper for employers who permit these methods in addition to online enrollment). Given the widespread use of online enrollment, this safe harbor is welcome news, as it imposes no conditions other than that the individual enroll or renew online. Reading this safe harbor in conjunction with the “on behalf of” relief (discussed above), an SBC provided electronically to a participant enrolling or renewing online will be treated as being provided to related beneficiaries.

**Example:** SBC Distribution With Online Enrollment. High-Tech Co. provides SBCs electronically both in connection with its annual open enrollment and at other times (e.g., special enrollment). All enrollments must be completed online. High-Tech satisfies the electronic distribution requirement so long as:

- ❖ The SBC is provided electronically in connection with the online enrollment process; and
- ❖ Participants and beneficiaries have the right to receive the SBC in paper format, free of charge, on request.

## Electronic Delivery Rules: No Online Enrollment

For ERISA plans, the SBC may be provided to covered participants and beneficiaries electronically, where online enrollment does not apply, if the requirements of the DOL's electronic disclosure safe harbor are met. The DOL safe harbor imposes strict requirements to ensure that the information sent electronically is sent by means that are “reasonably calculated to result in actual receipt.” It also contains an affirmative consent requirement for individuals who are not employees (e.g., for beneficiaries).

For participants and beneficiaries who are eligible but not enrolled, the SBC may be provided electronically (**where online enrollment does not apply**) if the format is readily accessible and a paper form is provided free of charge upon request. The SBC may be provided to these participants and beneficiaries via Internet posting if the participants and beneficiaries are notified in paper form (**such as a postcard**) or via email that the documents are available on the Internet. The postcard or email must provide the Internet address and indicate that the documents are available in paper form upon request. The agencies have provided model language (**which can be tailored by plans and insurers**) to meet the requirement to provide an e-card or postcard in connection with website postings to inform employees of the availability of an SBC.

Model Postcard Language is provided below.

## Model Language for SBC Postcard / eCard

Q

- Can the Departments provide model language to meet the requirement to provide an e-card or postcard in connection with evergreen website postings?

A

- Yes. Plans and issuers have flexibility with respect to the postcard and may choose to tailor it in many ways. One example is:

### **Availability of Summary Health Information**

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

The SBC is available on the web at: [www.website.com/SBC](http://www.website.com/SBC). A paper copy is also available, free of charge, by calling 1-XXX-XXX-XXXX (a toll-free number).

### Source FAQs About Affordable Care Act Implementation Part VIII

(<http://www.dol.gov/ebsa/faqs/faq-aca8.html>)

# CAREERSOURCE TAMPA BAY

## FLEXIBLE SPENDING ACCOUNT

PLAN DOCUMENT

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### Plan Number 502

Established as of **January 1, 2018**  
Amended and Restated as of **September 1, 2018**



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# CAREERSOURCE TAMPA BAY FLEXIBLE SPENDING ACCOUNT

## INTRODUCTION

The Employer has amended this Plan effective September 1, 2018, to recognize the contribution made to the Employer by its Employees. Its purpose is to reward them by providing benefits for those Employees who shall qualify hereunder and their Dependents and beneficiaries. The concept of this Plan is to allow Employees to choose among different types of benefits based on their own particular goals, desires and needs. This Plan is a restatement of a Plan which was originally effective on January 1, 2018. The Plan shall be known as CareerSource Tampa Bay Flexible Spending Account (the "Plan").

The intention of the Employer is that the Plan qualify as a "Cafeteria Plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, and that the benefits which an Employee elects to receive under the Plan be excludable from the Employee's income under Section 125(a) and other applicable sections of the Internal Revenue Code of 1986, as amended.

## ARTICLE I DEFINITIONS

1.1 **"Administrator"** means the Employer unless another person or entity has been designated by the Employer pursuant to Section 9.1 to administer the Plan on behalf of the Employer. If the Employer is the Administrator, the Employer may appoint any person, including, but not limited to, the Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.

1.2 **"Affiliated Employer"** means the Employer and any corporation which is a member of a controlled group of corporations (as defined in Code Section 414(b)) which includes the Employer; any trade or business (whether or not incorporated) which is under common control (as defined in Code Section 414(c)) with the Employer; any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Employer; and any other entity required to be aggregated with the Employer pursuant to Treasury regulations under Code Section 414(o).

1.3 **"Benefit" or "Benefit Options"** means any of the optional benefit choices available to a Participant as outlined in Section 4.1.

1.4 **"Cafeteria Plan Benefit Dollars"** means the amount available to Participants to purchase Benefit Options as provided under Section 4.1. Each dollar contributed to this Plan shall be converted into one Cafeteria Plan Benefit Dollar.

1.5 **"Code"** means the Internal Revenue Code of 1986, as amended or replaced from time to time.

1.6 **"Compensation"** means the amounts received by the Participant from the Employer during a Plan Year.

1.7 **"Dependent"** means any individual who qualifies as a dependent under an Insurance Contract for purposes of coverage under that Contract only or under Code Section 152 (as modified by Code Section 105(b)). Any child of a Plan Participant who is determined to be an alternate recipient under a qualified medical child support order under ERISA Sec. 609 shall be considered a Dependent under this Plan.

**"Dependent"** shall include any Child of a Participant who is covered under an Insurance Contract, as defined in the Contract, or under the Health Flexible Spending Account or as allowed by reason of the Affordable Care Act.

For purposes of the Health Flexible Spending Account, a Participant's "Child" includes his/her natural child, stepchild, foster child, adopted child, or a child placed with the Participant for adoption. A Participant's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end at the end of the calendar year.

The phrase "placed for adoption" refers to a child whom the Participant intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

1.8 **"Effective Date"** means January 1, 2018.

1.9 **"Election Period"** means the period immediately preceding the beginning of each Plan Year established by the Administrator, such period to be applied on a uniform and nondiscriminatory basis for all Employees and Participants. However, an Employee's initial Election Period shall be determined pursuant to Section 5.1.

1.10 **"Eligible Employee"** means any Employee who has satisfied the provisions of Section 2.1.

An individual shall not be an "Eligible Employee" if such individual is not reported on the payroll records of the Employer as a common law employee. In particular, it is expressly intended that individuals not treated as common law employees by the Employer on its payroll records are not "Eligible Employees" and are excluded from Plan participation even if a court or administrative agency determines that such individuals are common law employees and not independent contractors.

However, any Employee who is a "part-time" Employee shall not be eligible to participate in this Plan. A "part-time" Employee is any Employee who works, or is expected to work on a regular basis, less than 30 hours a week and is designated as a part-time Employee on the Employer's personnel records.

1.11 **"Employee"** means any person who is employed by the Employer. The term Employee shall include leased employees within the meaning of Code Section 414(n)(2).

1.12 **"Employer"** means Tampa Bay Workforce Alliance, Inc. DBA CareerSource Tampa Bay and any successor which shall maintain this Plan; and any predecessor which has maintained this Plan. In addition, where appropriate, the term Employer shall include any Participating, Affiliated or Adopting Employer.

1.13 **"ERISA"** means the Employee Retirement Income Security Act of 1974, as amended from time to time.

1.14 **"Insurance Contract"** means any contract issued by an Insurer underwriting a Benefit.

1.15 **"Insurance Premium Payment Plan"** means the plan of benefits contained in Section 4.1 of this Plan, which provides for the payment of Premium Expenses.

1.16 **"Insurer"** means any insurance company that underwrites a Benefit under this Plan.

1.17 **"Key Employee"** means an Employee described in Code Section 416(i)(1) and the Treasury regulations thereunder.

1.18 **"Participant"** means any Eligible Employee who elects to become a Participant pursuant to Section 2.3 and has not for any reason become ineligible to participate further in the Plan.

1.19 **"Plan"** means this instrument, including all amendments thereto.

1.20 **"Plan Year"** means the 12-month period beginning January 1 and ending December 31. The Plan Year shall be the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant's date of entry and ending on the last day of such Plan Year.

1.21 **"Premium Expenses"** or **"Premiums"** mean the Participant's cost for the Benefits described in Section 4.1.

1.22 **"Premium Expense Reimbursement Account"** means the account established for a Participant pursuant to this Plan to which part of his Cafeteria Plan Benefit Dollars may be

allocated and from which Premiums of the Participant may be paid or reimbursed. If more than one type of insured Benefit is elected, sub-accounts shall be established for each type of insured Benefit.

1.23 **"Salary Redirection"** means the contributions made by the Employer on behalf of Participants pursuant to Section 3.1. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V.

1.24 **"Salary Redirection Agreement"** means an agreement between the Participant and the Employer under which the Participant agrees to reduce his Compensation or to forego all or part of the increases in such Compensation and to have such amounts contributed by the Employer to the Plan on the Participant's behalf. The Salary Redirection Agreement shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Plan and Code Section 125 into account) and, subsequently does not become currently available to the Participant.

1.25 **"Spouse"** means spouse as determined under Federal law.

## **ARTICLE II PARTICIPATION**

### **2.1 ELIGIBILITY**

Any Eligible Employee shall be eligible to participate hereunder 30 days after his initial date of employment with the Employer. However, any Eligible Employee who was a Participant in the Plan on the effective date of this amendment shall continue to be eligible to participate in the Plan.

### **2.2 EFFECTIVE DATE OF PARTICIPATION**

An Eligible Employee shall become a Participant effective as of the first day of the month following the date on which he met the eligibility requirements of Section 2.1.

### **2.3 APPLICATION TO PARTICIPATE**

An Employee who is eligible to participate in this Plan shall, during the applicable Election Period, complete an application to participate in a manner set forth by the Administrator. The election shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change his Benefit elections pursuant to Section 5.4 hereof.

An Eligible Employee shall also be required to complete a Salary Redirection Agreement during the Election Period for the Plan Year during which he wishes to participate in this Plan. Any such Salary Redirection Agreement shall be effective for the first pay period beginning on or after the Employee's effective date of participation pursuant to Section 2.2.

## 2.4 TERMINATION OF PARTICIPATION

A Participant shall no longer participate in this Plan upon the occurrence of any of the following events:

- (a) **Termination of employment.** The Participant's termination of employment, subject to the provisions of Section 2.6;
- (b) **Change in employment status.** The end of the Plan Year during which the Participant became a limited Participant because of a change in employment status pursuant to Section 2.5;
- (c) **Death.** The Participant's death, subject to the provisions of Section 2.7; or
- (d) **Termination of the plan.** The termination of this Plan, subject to the provisions of Section 10.2.

## 2.5 CHANGE OF EMPLOYMENT STATUS

If a Participant ceases to be eligible to participate because of a change in employment status or classification (other than through termination of employment), the Participant shall become a limited Participant in this Plan for the remainder of the Plan Year in which such change of employment status occurs. As a limited Participant, no further Salary Redirection may be made on behalf of the Participant, and, except as otherwise provided herein, all further Benefit elections shall cease, subject to the limited Participant's right to continue coverage under any Insurance Contracts. However, any balances in the limited Participant's Dependent Care Flexible Spending Account may be used during such Plan Year to reimburse the limited Participant for any allowable Employment-Related Dependent Care incurred during the Plan Year. Subject to the provisions of Section 2.6, if the limited Participant later becomes an Eligible Employee, then the limited Participant may again become a full Participant in this Plan, provided he otherwise satisfies the participation requirements set forth in this Article II as if he were a new Employee and made an election in accordance with Section 5.1.

## 2.6 TERMINATION OF EMPLOYMENT

If a Participant's employment with the Employer is terminated for any reason other than death, his participation in the Benefit Options provided under Section 4.1 shall be governed in accordance with the following:

- (a) **Insurance Benefit.** With regard to Benefits which are insured, the Participant's participation in the Plan shall cease, subject to the Participant's right to continue coverage under any Insurance Contract for which premiums have already been paid. A terminated employee will lose coverage per the timeframe determined in the underlying documents for each benefit.

(b) **Dependent Care FSA.** With regard to the Dependent Care Flexible Spending Account, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for employment related Dependent Care Expense reimbursements for claims incurred up to midnight of the date of termination and submitted within 30 days after termination, based on the level of the Participant's Dependent Care Flexible Spending Account as of the date of termination.

(c) **COBRA applicability.** With regard to the Health Flexible Spending Account, the Participant may submit claims for expenses that were incurred prior to midnight of the date of termination and submitted within 30 days after termination. Thereafter, the health benefits under this Plan including the Health Flexible Spending Account shall be applied and administered consistent with such further rights a Participant and his Dependents may be entitled to pursuant to Code Section 4980B and Section 11.14 of the Plan.

## **2.7 DEATH**

If a Participant dies, his participation in the Plan shall cease. However, such Participant's spouse or Dependents may submit claims for expenses or benefits for the remainder of the Plan Year or until the Cafeteria Plan Benefit Dollars allocated to each specific benefit are exhausted. In no event may reimbursements be paid to someone who is not a spouse or Dependent. If the Plan is subject to the provisions of Code Section 4980B, then those provisions and related regulations shall apply for purposes of the Health Flexible Spending Account.

## **ARTICLE III CONTRIBUTIONS TO THE PLAN**

### **3.1 SALARY REDIRECTION**

Benefits under the Plan shall be financed by Salary Redirections sufficient to support Benefits that a Participant has elected hereunder and to pay the Participant's Premium Expenses. The salary administration program of the Employer shall be revised to allow each Participant to agree to reduce his pay during a Plan Year by an amount determined necessary to purchase the elected Benefit Options. The amount of such Salary Redirection shall be specified in the Salary Redirection Agreement and shall be applicable for a Plan Year. Notwithstanding the above, for new Participants, the Salary Redirection Agreement shall only be applicable from the first day of the pay period following the Employee's entry date up to and including the last day of the Plan Year. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article IV.

Any Salary Redirection shall be determined prior to the beginning of a Plan Year (subject to initial elections pursuant to Section 5.1) and prior to the end of the Election Period and shall be irrevocable for such Plan Year. However, a Participant may revoke a Benefit election or a

Salary Redirection Agreement after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted events as determined under Article V of the Plan and consistent with the rules and regulations of the Department of the Treasury. Salary Redirection amounts shall be contributed on a pro rata basis for each pay period during the Plan Year. All individual Salary Redirection Agreements are deemed to be part of this Plan and incorporated by reference hereunder.

### **3.2 APPLICATION OF CONTRIBUTIONS**

As soon as reasonably practical after each payroll period, the Employer shall apply the Salary Redirection to provide the Benefits elected by the affected Participants. Any contribution made or withheld for the Health Flexible Spending Account or Dependent Care Flexible Spending Account shall be credited to such fund or account. Amounts designated for the Participant's Premium Expense Reimbursement Account shall likewise be credited to such account for the purpose of paying Premium Expenses.

### **3.3 PERIODIC CONTRIBUTIONS**

Notwithstanding the requirement provided above and in other Articles of this Plan that Salary Redirections be contributed to the Plan by the Employer on behalf of an Employee on a level and pro rata basis for each payroll period, the Employer and Administrator may implement a procedure in which Salary Redirections are contributed throughout the Plan Year on a periodic basis that is not pro rata for each payroll period. However, with regard to the Health Flexible Spending Account, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the Plan Year.

## **ARTICLE IV BENEFITS**

### **4.1 BENEFIT OPTIONS**

Each Participant may elect any one or more of the following optional Benefits:

- (1) Health Flexible Spending Account
- (2) Dependent Care Flexible Spending Account
- (3) Insurance Premium Payment Plan
  - (i) Health Insurance Benefit
  - (ii) Dental Insurance Benefit
  - (iii) Vision Insurance Benefit

(iv) Specified Voluntary Worksite Insurance Benefit

(4) Health Savings Account Benefit

#### **4.2 HEALTH FLEXIBLE SPENDING ACCOUNT BENEFIT**

Each Participant may elect to participate in the Health Flexible Spending Account option, in which case Article VI shall apply.

#### **4.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFIT**

Each Participant may elect to participate in the Dependent Care Flexible Spending Account option, in which case Article VII shall apply.

#### **4.4 HEALTH INSURANCE BENEFIT**

(a) **Coverage for Participant and Dependents.** Each Participant may elect to be covered under a health Insurance Contract for the Participant, his or her Spouse, and his or her Dependents.

(b) **Employer selects contracts.** The Employer may select suitable health Insurance Contracts for use in providing this health insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such health Insurance Contract shall be determined therefrom, and such Insurance Contract shall be incorporated herein by reference.

#### **4.5 DENTAL INSURANCE BENEFIT**

(a) **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's dental Insurance Contract. In addition, the Participant may elect either individual or family coverage under such Insurance Contract.

(b) **Employer selects contracts.** The Employer may select suitable dental Insurance Contracts for use in providing this dental insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such dental Insurance Contract shall be determined therefrom, and such dental Insurance Contract shall be incorporated herein by reference.



#### 4.6 VISION INSURANCE BENEFIT

(a) **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's vision Insurance Contract. In addition, the Participant may elect either individual or family coverage.

(b) **Employer selects contracts.** The Employer may select suitable vision Insurance Contracts for use in providing this vision insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such vision Insurance Contract shall be determined therefrom, and such vision Insurance Contract shall be incorporated herein by reference.

#### 4.7 SPECIFIED VOLUNTARY WORKSITE INSURANCE BENEFIT

(a) **Coverage for Participant and/or Dependents.** Each Participant may elect to be covered under the Employer's specified voluntary worksite Insurance Contract. In addition, the Participant may elect either individual or family coverage.

(b) **Employer selects contracts.** The Employer may select suitable specified voluntary worksite Insurance Contracts for use in providing this specified voluntary worksite insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) **Contract incorporated by reference.** The rights and conditions with respect to the benefits payable from such specified voluntary worksite Insurance Contract shall be determined therefrom, and such specified voluntary worksite Insurance Contract shall be incorporated herein by reference.

#### 4.8 HEALTH SAVINGS ACCOUNT BENEFIT

Each Participant may elect to have a portion of his Salary Redirections contributed to a Health Savings Account, as defined in Code Section 223. The amounts contributed shall be subject to the terms of the Health Savings Account as established. The maximum amount that may be contributed to the Health Savings Account shall be subject to the provisions of Code Section 223, as modified or adjusted from time to time by the Internal Revenue Service (IRS), and shall be automatically adjusted to the maximum annual contribution amounts established by the IRS for each calendar year.

#### 4.9 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Plan to provide benefits to a classification of employees which the Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125.

(b) **25% concentration test.** It is the intent of this Plan not to provide qualified benefits as defined under Code Section 125 to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for all Eligible Employees under the Plan. For purposes of the preceding sentence, qualified benefits shall not include benefits which (without regard to this paragraph) are includible in gross income.

(c) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible taxation to Key Employees or a group of employees in whose favor discrimination may not occur in violation of Code Section 125, it may, but shall not be required to, reject any election or reduce contributions or non-taxable Benefits in order to assure compliance with the Code and regulations. Any act taken by the Administrator shall be carried out in a uniform and nondiscriminatory manner. With respect to any affected Participant who has had Benefits reduced pursuant to this Section, the reduction shall be made proportionately among Health Flexible Spending Account Benefits and Dependent Care Flexible Spending Account Benefits, and once all these Benefits are expended, proportionately among insured Benefits. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.

## **ARTICLE V PARTICIPANT ELECTIONS**

### **5.1 INITIAL ELECTIONS**

An Employee who meets the eligibility requirements of Section 2.1 on the first day of, or during, a Plan Year may elect to participate in this Plan for all or the remainder of such Plan Year, provided he elects to do so on or before his effective date of participation pursuant to Section 2.2.

### **5.2 SUBSEQUENT ANNUAL ELECTIONS**

During the Election Period prior to each subsequent Plan Year, each Participant shall be given the opportunity to elect, on an election of benefits form to be provided by the Administrator, which Benefit options he wishes to select. Any such election shall be effective for any Benefit expenses incurred during the Plan Year which follows the end of the Election Period. With regard to subsequent annual elections, the following options shall apply:

(a) A Participant or Employee who failed to initially elect to participate may elect different or new Benefits under the Plan during the Election Period;

(b) A Participant may terminate his participation in the Plan by notifying the Administrator in writing during the Election Period that he does not want to participate in the Plan for the next Plan Year, or by not electing any Benefit options;

(c) An Employee who elects not to participate for the Plan Year following the Election Period will have to wait until the next Election Period before again electing to participate in the Plan, except as provided for in Section 5.4.

### **5.3 FAILURE TO ELECT**

Any Participant failing to complete an election of benefits form pursuant to Section 5.2 by the end of the applicable Election Period shall be deemed to have elected not to participate in the Plan for the upcoming Plan Year. No further Salary Redirections shall therefore be authorized for such subsequent Plan Year.

### **5.4 CHANGE IN STATUS**

(a) **Change in status defined.** Any Participant may change a Benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, the changes are necessitated by and are consistent with a change in status which is acceptable under rules and regulations adopted by the Department of the Treasury, the provisions of which are incorporated by reference. Notwithstanding anything herein to the contrary, if the rules and regulations conflict, then such rules and regulations shall control.

In general, a change in election is not consistent if the change in status is the Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverage, and the Participant's election under the Plan is to cancel accident or health insurance coverage for any individual other than the one involved in such event. In addition, if the Participant, Spouse or Dependent gains or loses eligibility for coverage, then a Participant's election under the Plan to cease or decrease coverage for that individual under the Plan corresponds with that change in status only if coverage for that individual becomes applicable or is increased under the family member plan.

Regardless of the consistency requirement, if the individual, the individual's Spouse, or Dependent becomes eligible for continuation coverage under the Employer's group health plan as provided in Code Section 4980B or any similar state law, then the individual may elect to increase payments under this Plan in order to pay for the continuation coverage. However, this does not apply for COBRA eligibility due to divorce, annulment or legal separation.

Any new election shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Administrator. All new elections must be submitted via the form determined by the Administrator within 30 days of the change in status, notwithstanding any rule or regulation to the contrary. For the purposes of this

subsection, a change in status shall only include the following events or other events permitted by Treasury regulations:

- (1) **Legal Marital Status:** events that change a Participant's legal marital status, including marriage, divorce, death of a Spouse, legal separation or annulment;
- (2) **Number of Dependents:** Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent;
- (3) **Employment Status:** Any of the following events that change the employment status of the Participant, Spouse, or Dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer of the Participant, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection;
- (4) **Dependent satisfies or ceases to satisfy the eligibility requirements:** An event that causes the Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance; and
- (5) **Residency:** A change in the place of residence of the Participant, Spouse or Dependent, that would lead to a change in status (such as a loss of HMO coverage).

For the Dependent Care Flexible Spending Account, a Dependent becoming or ceasing to be a "Qualifying Dependent" as defined under Code Section 21(b) shall also qualify as a change in status.

Notwithstanding anything in this Section to the contrary, the gain of eligibility or change in eligibility of a child, as allowed under Code Sections 105(b) and 106, and guidance thereunder, shall qualify as a change in status.

(b) **Special enrollment rights.** Notwithstanding subsection (a), the Participants may change an election for group health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f), including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (SCHIP); provided that such Participant meets the sixty (60) day notice requirement imposed by Code Section 9801(f) (or such longer period as may be permitted by the Plan and communicated to Participants). Such change shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.

(c) **Qualified Medical Support Order.** Notwithstanding subsection (a), in the event of a judgment, decree, or order (including approval of a property settlement ("order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in ERISA Section 609) which requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant):

(1) The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's plan; or

(2) The Participant shall be permitted to change an election to cancel coverage for the child if the order requires the former Spouse to provide coverage for such child, under that individual's plan and such coverage is actually provided.

(d) **Medicare or Medicaid.** Notwithstanding subsection (a), a Participant may change elections to cancel accident or health coverage for the Participant or the Participant's Spouse or Dependent if the Participant or the Participant's Spouse or Dependent is enrolled in the accident or health coverage of the Employer and becomes entitled to coverage (i.e., enrolled) under Part A or Part B of the Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). If the Participant or the Participant's Spouse or Dependent who has been entitled to Medicaid or Medicare coverage loses eligibility, that individual may prospectively elect coverage under the Plan if a benefit package option under the Plan provides similar coverage.

(e) **Cost increase or decrease.** If the cost of a Benefit provided under the Plan increases or decreases during a Plan Year, then the Plan shall automatically increase or decrease, as the case may be, the Salary Redirections of all affected Participants for such Benefit. Alternatively, if the cost of a benefit package option increases significantly, the Administrator shall permit the affected Participants to either make corresponding changes in their payments or revoke their elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage, or drop coverage prospectively if there is no benefit package option with similar coverage.

A cost increase or decrease refers to an increase or decrease in the amount of elective contributions under the Plan, whether resulting from an action taken by the Participants or an action taken by the Employer.

(f) **Loss of coverage.** If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.

(g) **Addition of a new benefit.** If, during the period of coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then the affected Participants may elect the newly-added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, those Eligible Employees who are not participating in the Plan may opt to become Participants and elect the new or newly improved benefit package option.

(h) **Loss of coverage under certain other plans.** A Participant may make a prospective election change to add group health coverage for the Participant, the Participant's Spouse or Dependent if such individual loses group health coverage sponsored by a governmental or educational institution, including a state children's health insurance program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.

(i) **Change of coverage due to change under certain other plans.** A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of a Spouse's, former Spouse's or Dependent's employer if (1) the cafeteria plan or other benefits plan of the Spouse's, former Spouse's or Dependent's employer permits its participants to make a change; or (2) the cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan of a Spouse's, former Spouse's or Dependent's employer.

(j) **Change in dependent care provider.** A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care provider. The availability of dependent care services from a new childcare provider is similar to a new benefit package option becoming available. A cost change is allowable in the Dependent Care Flexible Spending Account only if the cost change is imposed by a dependent care provider who is not related to the Participant, as defined in Code Section 152(a)(1) through (8).

(k) **Health FSA cannot change due to insurance change.** A Participant shall not be permitted to change an election to the Health Flexible Spending Account as a result of a cost or coverage change under any health insurance benefits.

(l) **Health Savings Account changes.** With regard to the Health Savings Account Benefit specified in Section 4.8, a Participant who has elected to make elective contributions under such arrangement may modify or revoke the election prospectively, provided such change is consistent with Code Section 223 and the Treasury regulations thereunder.

(m) **Changes due to reduction in hours or enrollment in an Exchange**

**Plan.** A Participant may prospectively revoke coverage under the group health plan (that is not a health Flexible Spending Account) which provides minimum essential coverage (as defined in Code §5000A(f)(1)) provided the following conditions are met:

Conditions for revocation due to reduction in hours of service:

- (1) The Participant has been reasonably expected to average at least 30 hours of service per week and there is a change in that Participant's status so that the Participant will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the Participant ceasing to be eligible under the group health plan; and
- (2) The revocation of coverage under the group health plan corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

The Administrator may rely on the reasonable representation of the Participant who is reasonably expected to have an average of less than 30 hours of service per week for future periods that the Participant and related individuals have enrolled or intend to enroll in another plan that provides minimum essential coverage for new coverage that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

Conditions for revocation due to enrollment in a Qualified Health Plan:

- (1) The Participant is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace (federal or state exchange) pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance; and
- (2) The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the Participant and any related individuals who cease coverage due to the revocation in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

The Administrator may rely on the reasonable representation of a Participant who has an enrollment opportunity for a Qualified Health Plan through a Marketplace that the Participant and related individuals have enrolled or intend to enroll in a Qualified Health Plan for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

## ARTICLE VI HEALTH FLEXIBLE SPENDING ACCOUNT

### 6.1 ESTABLISHMENT OF PLAN

This Health Flexible Spending Account is intended to qualify as a medical reimbursement plan under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder. Participants who elect to participate in this Health Flexible Spending Account may submit claims for the reimbursement of Medical Expenses. All amounts reimbursed shall be periodically paid from amounts allocated to the Health Flexible Spending Account. Periodic payments reimbursing Participants from the Health Flexible Spending Account shall in no event occur less frequently than monthly. Participants who elect to participate in this Health Flexible Spending Account are not eligible individuals for purposes of making contributions to the Health Savings Account during the entire plan year of the Health Flexible Spending Account without regard to the amount available from the Health Flexible Spending Account for any month during the Plan Year. Thus, a Participant covered by a Health Flexible Spending Account solely as the result of a carryover of unused amounts in a Health Flexible Spending Account may not contribute to a Health Savings Account, even for months in the Plan Year after the Health Flexible Spending Account no longer has any amounts available to pay or reimburse medical expenses.

### 6.2 DEFINITIONS

For the purposes of this Article and the Cafeteria Plan, the terms below have the following meaning:

- (a) **"Health Flexible Spending Account"** means the account established for Participants pursuant to this Plan to which part of their Cafeteria Plan Benefit Dollars may be allocated and from which all allowable Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents may be reimbursed.
- (b) **"Highly Compensated Participant"** means, for the purposes of this Article and determining discrimination under Code Section 105(h), a participant who is:
  - (1) one of the 5 highest paid officers;
  - (2) a shareholder who owns (or is considered to own applying the rules of Code Section 318) more than 10 percent in value of the stock of the Employer; or
  - (3) among the highest paid 25 percent of all Employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants).
- (c) **"Medical Expenses"** means any expense for medical care within the meaning of the term "medical care" as defined in Code Section 213(d) and the rulings and



Treasury regulations thereunder, and not otherwise used by the Participant as a deduction in determining his tax liability under the Code. "Medical Expenses" can be incurred by the Participant, his or her Spouse and his or her Dependents. "Incurred" means, with regard to Medical Expenses, when the Participant is provided with the medical care that gives rise to the Medical Expense and not when the Participant is formally billed or charged for, or pays for, the medical care.

A Participant may not be reimbursed for the cost of any medicine or drug that is not "prescribed" within the meaning of Code Section 106(f) or is not insulin.

A Participant may not be reimbursed for the cost of other health coverage such as premiums paid under plans maintained by the employer of the Participant's Spouse or individual policies maintained by the Participant or his Spouse or Dependent.

A Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).

(d) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Flexible Spending Account.

### **6.3 FORFEITURES**

The amount in the Health Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 6.7 hereof, excluding any carryover) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to Section 8.2.

### **6.4 LIMITATION ON ALLOCATIONS**

(a) Notwithstanding any provision contained in this Health Flexible Spending Account to the contrary, the maximum amount of salary reductions that may be allocated to the Health Flexible Spending Account by a Participant in or on account of any Plan Year, beginning with 2018, is \$2,650, as adjusted for increases in the cost of living in accordance with Code Section 125(i)(2). The cost of living adjustment in effect for a calendar year applies to any Plan Year beginning with or within such calendar year. The dollar increase in effect on January 1 of any calendar year shall be effective for the Plan Year beginning with or within such calendar year. For any short Plan Year, the limit shall be an amount equal to the limit for the calendar year in which the Plan Year begins multiplied by the ratio obtained by dividing the number of full months in the short Plan Year by twelve (12).

(b) **Participation in Other Plans.** All employers that are treated as a single employer under Code Sections 414(b), (c), or (m), relating to controlled groups and affiliated service groups, are treated as a single employer for purposes of the statutory limit. If a Participant participates in multiple cafeteria plans offering health flexible

spending accounts maintained by members of a controlled group or affiliated service group, the Participant's total Health Flexible Spending Account contributions under all of the cafeteria plans are limited to the statutory limit (as adjusted). However, a Participant employed by two or more employers that are not members of the same controlled group may elect up to the statutory limit (as adjusted) under each Employer's Health Flexible Spending Account.

(c) **Carryover.** A Participant in the Health Flexible Spending Account may roll over up to \$500 of unused amounts in the Health Flexible Spending Account remaining at the end of one Plan Year to the immediately following Plan Year. These amounts can be used during the following Plan Year for expenses incurred in that Plan Year. Amounts carried over do not affect the maximum amount of salary redirection contributions for the Plan Year to which they are carried over. Unused amounts are those remaining after expenses have been reimbursed during the runout period. These amounts may not be cashed out or converted to any other taxable or nontaxable benefit. Amounts in excess of \$500 will be forfeited. The Plan is allowed, but not required, to treat claims as being paid first from the current year amounts, then from the carryover amounts.

## 6.5 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Health Flexible Spending Account not to discriminate in violation of the Code and the Treasury regulations thereunder.

(b) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination under this Health Flexible Spending Account, it may, but shall not be required to, reject any elections or reduce contributions or Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Health Flexible Spending Account by the member of the group in whose favor discrimination may not occur pursuant to Code Section 105 that elected to contribute the highest amount to the fund for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section or the Code are satisfied, or until the amount designated for the fund equals the amount designated for the fund by the next member of the group in whose favor discrimination may not occur pursuant to Code Section 105 who has elected the second highest contribution to the Health Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section or the Code are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and credited to the benefit plan surplus.

## 6.6 COORDINATION WITH CAFETERIA PLAN

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Health Flexible Spending Account. The enrollment under the Cafeteria Plan shall constitute enrollment under this Health Flexible Spending Account. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

## 6.7 HEALTH FLEXIBLE SPENDING ACCOUNT CLAIMS

(a) **Expenses must be incurred during Plan Year.** All Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents during the Plan Year shall be reimbursed during the Plan Year subject to Section 2.6, even though the submission of such a claim occurs after his participation hereunder ceases; but provided that the Medical Expenses were incurred during the applicable Plan Year. Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for, or pays for the medical care.

(b) **Reimbursement available throughout Plan Year.** The Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount designated by the Participant for the Health Flexible Spending Account for the Plan Year. Reimbursements shall be made available to the Participant throughout the year without regard to the level of Cafeteria Plan Benefit Dollars which have been allocated to the fund at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering the Participant and/or his Spouse or Dependents.

(c) **Payments.** Reimbursement payments under this Plan shall be made directly to the Participant. However, in the Administrator's discretion, payments may be made directly to the service provider. The application for payment or reimbursement shall be made to the Administrator on an acceptable form within a reasonable time of incurring the debt or paying for the service. The application shall include a written statement from an independent third party stating that the Medical Expense has been incurred and the amount of such expense. Furthermore, the Participant shall provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Health Flexible Spending Account, such amount will not be claimed as a tax deduction. The Administrator shall retain a file of all such applications.

(d) **Claims for reimbursement.** Claims for the reimbursement of Medical Expenses incurred in any Plan Year shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those Medical Expense claims shall not be considered for reimbursement by the Administrator. However, if a Participant

terminates employment during the Plan Year, claims for the reimbursement of Medical Expenses must be submitted within 30 days after termination of employment.

## **ARTICLE VII DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT**

### **7.1 ESTABLISHMENT OF ACCOUNT**

This Dependent Care Flexible Spending Account is intended to qualify as a program under Code Section 129 and shall be interpreted in a manner consistent with such Code Section. Participants who elect to participate in this program may submit claims for the reimbursement of Employment-Related Dependent Care Expenses. All amounts reimbursed shall be paid from amounts allocated to the Participant's Dependent Care Flexible Spending Account.

### **7.2 DEFINITIONS**

For the purposes of this Article and the Cafeteria Plan the terms below shall have the following meaning:

(a) **"Dependent Care Flexible Spending Account"** means the account established for a Participant pursuant to this Article to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which Employment-Related Dependent Care Expenses of the Participant may be reimbursed for the care of the Qualifying Dependents of Participants.

(b) **"Earned Income"** means earned income as defined under Code Section 32(c)(2), but excluding such amounts paid or incurred by the Employer for dependent care assistance to the Participant.

(c) **"Employment-Related Dependent Care Expenses"** means the amounts paid for expenses of a Participant for those services which if paid by the Participant would be considered employment related expenses under Code Section 21(b)(2). Generally, they shall include expenses for household services and for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any period for which there are one or more Qualifying Dependents with respect to such Participant. Employment-Related Dependent Care Expenses are treated as having been incurred when the Participant's Qualifying Dependents are provided with the dependent care that gives rise to the Employment-Related Dependent Care Expenses, not when the Participant is formally billed or charged for, or pays for the dependent care. The determination of whether an amount qualifies as an Employment-Related Dependent Care Expense shall be made subject to the following rules:

(1) If such amounts are paid for expenses incurred outside the Participant's household, they shall constitute Employment-Related Dependent Care Expenses only if incurred for a Qualifying Dependent as defined in Section 7.2(d)(1) (or

deemed to be, as described in Section 7.2(d)(1) pursuant to Section 7.2(d)(3)), or for a Qualifying Dependent as defined in Section 7.2(d)(2) (or deemed to be, as described in Section 7.2(d)(2) pursuant to Section 7.2(d)(3)) who regularly spends at least 8 hours per day in the Participant's household;

(2) If the expense is incurred outside the Participant's home at a facility that provides care for a fee, payment, or grant for more than 6 individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any; and

(3) Employment-Related Dependent Care Expenses of a Participant shall not include amounts paid or incurred to a child of such Participant who is under the age of 19 or to an individual who is a Dependent of such Participant or such Participant's Spouse.

(d) **"Qualifying Dependent"** means, for Dependent Care Flexible Spending Account purposes,

(1) a Participant's Dependent (as defined in Code Section 152(a)(1)) who has not attained age 13;

(2) a Dependent or the Spouse of a Participant who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the Participant for more than one-half of such taxable year; or

(3) a child that is deemed to be a Qualifying Dependent described in paragraph (1) or (2) above, whichever is appropriate, pursuant to Code Section 21(e)(5).

(e) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Dependent Care Flexible Spending Account.

### **7.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS**

The Administrator shall establish a Dependent Care Flexible Spending Account for each Participant who elects to apply Cafeteria Plan Benefit Dollars to Dependent Care Flexible Spending Account benefits.

### **7.4 INCREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS**

A Participant's Dependent Care Flexible Spending Account shall be increased each pay period by the portion of Cafeteria Plan Benefit Dollars that he has elected to apply toward his Dependent Care Flexible Spending Account pursuant to elections made under Article V hereof.

## **7.5 DECREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS**

A Participant's Dependent Care Flexible Spending Account shall be reduced by the amount of any Employment-Related Dependent Care Expense reimbursements paid or incurred on behalf of a Participant pursuant to Section 7.12 hereof.

## **7.6 ALLOWABLE DEPENDENT CARE REIMBURSEMENT**

Subject to limitations contained in Section 7.9 of this Program, and to the extent of the amount contained in the Participant's Dependent Care Flexible Spending Account, a Participant who incurs Employment-Related Dependent Care Expenses shall be entitled to receive from the Employer full reimbursement for the entire amount of such expenses incurred during the Plan Year or portion thereof during which he is a Participant.

## **7.7 ANNUAL STATEMENT OF BENEFITS**

On or before January 31st of each calendar year, the Employer shall furnish to each Employee who was a Participant and received benefits under Section 7.6 during the prior calendar year, a statement of all such benefits paid to or on behalf of such Participant during the prior calendar year. This statement is set forth on the Participant's Form W-2.

## **7.8 FORFEITURES**

The amount in a Participant's Dependent Care Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 7.12 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason.

## **7.9 LIMITATION ON PAYMENTS**

(a) **Code limits.** Notwithstanding any provision contained in this Article to the contrary, amounts paid from a Participant's Dependent Care Flexible Spending Account in or on account of any taxable year of the Participant shall not exceed the lesser of the Earned Income limitation described in Code Section 129(b) or \$5,000 (\$2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)).

## **7.10 NONDISCRIMINATION REQUIREMENTS**

(a) **Intent to be nondiscriminatory.** It is the intent of this Dependent Care Flexible Spending Account that contributions or benefits not discriminate in favor of the group of employees in whose favor discrimination may not occur under Code Section 129(d).

(b) **25% test for shareholders.** It is the intent of this Dependent Care Flexible Spending Account that not more than 25 percent of the amounts paid by the

Employer for dependent care assistance during the Plan Year will be provided for the class of individuals who are shareholders or owners (or their Spouses or Dependents), each of whom (on any day of the Plan Year) owns more than 5 percent of the stock or of the capital or profits interest in the Employer.

(c) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible taxation to a group of employees in whose favor discrimination may not occur in violation of Code Section 129 it may, but shall not be required to, reject any elections or reduce contributions or non-taxable benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Dependent Care Flexible Spending Account by the affected Participant that elected to contribute the highest amount to such account for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section are satisfied, or until the amount designated for the account equals the amount designated for the account of the affected Participant who has elected the second highest contribution to the Dependent Care Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited.

## **7.11 COORDINATION WITH CAFETERIA PLAN**

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Dependent Care Flexible Spending Account. The enrollment and termination of participation under the Cafeteria Plan shall constitute enrollment and termination of participation under this Dependent Care Flexible Spending Account. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

## **7.12 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT CLAIMS**

The Administrator shall direct the payment of all such Dependent Care claims to the Participant upon the presentation to the Administrator of documentation of such expenses in a form satisfactory to the Administrator. However, in the Administrator's discretion, payments may be made directly to the service provider. In its discretion in administering the Plan, the Administrator may utilize forms and require documentation of costs as may be necessary to verify the claims submitted. At a minimum, the form shall include a statement from an independent third party as proof that the expense has been incurred during the Plan Year and the amount of such expense. In addition, the Administrator may require that each Participant who desires to receive reimbursement under this Program for Employment-Related Dependent Care Expenses submit a statement which may contain some or all of the following information:

- (a) The Dependent or Dependents for whom the services were performed;

(b) The nature of the services performed for the Participant, the cost of which he wishes reimbursement;

(c) The relationship, if any, of the person performing the services to the Participant;

(d) If the services are being performed by a child of the Participant, the age of the child;

(e) A statement as to where the services were performed;

(f) If any of the services were performed outside the home, a statement as to whether the Dependent for whom such services were performed spends at least 8 hours a day in the Participant's household;

(g) If the services were being performed in a day care center, a statement:

(1) that the day care center complies with all applicable laws and regulations of the state of residence,

(2) that the day care center provides care for more than 6 individuals (other than individuals residing at the center), and

(3) of the amount of fee paid to the provider.

(h) If the Participant is married, a statement containing the following:

(1) the Spouse's salary or wages if he or she is employed, or

(2) if the Participant's Spouse is not employed, that

(i) he or she is incapacitated, or

(ii) he or she is a full-time student attending an educational institution and the months during the year which he or she attended such institution.

(i) **Claims for reimbursement.** If a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for reimbursement must be submitted within 30 days after termination of employment.



**ARTICLE VIII  
BENEFITS AND RIGHTS**

**8.1 CLAIM FOR BENEFITS**

(a) **Insurance claims.** Any claim for Benefits underwritten by Insurance Contract(s) shall be made to the Insurer. If the Insurer denies any claim, the Participant or beneficiary shall follow the Insurer's claims review procedure.

(b) **Dependent Care Flexible Spending Account claims.** Any claim for Dependent Care Flexible Spending Account Benefits shall be made to the Administrator. For the Dependent Care Flexible Spending Account, if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for reimbursement must be submitted within 30 days after termination of employment. If the Administrator denies a claim, the Administrator may provide notice to the Participant or beneficiary, in writing, within 90 days after the claim is filed unless special circumstances require an extension of time for processing the claim. The notice of a denial of a claim shall be written in a manner calculated to be understood by the claimant and shall set forth:

- (1) specific references to the pertinent Plan provisions on which the denial is based;
- (2) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation as to why such information is necessary; and
- (3) an explanation of the Plan's claim procedure.

(c) **Appeal.** Within 60 days after receipt of the above material, the claimant shall have a reasonable opportunity to appeal the claim denial to the Administrator for a full and fair review. The claimant or his duly authorized representative may:

- (1) request a review upon written notice to the Administrator;
- (2) review pertinent documents; and
- (3) submit issues and comments in writing.

(d) **Review of appeal.** A decision on the review by the Administrator will be made not later than 60 days after receipt of a request for review, unless special circumstances require an extension of time for processing (such as the need to hold a hearing), in which event a decision should be rendered as soon as possible, but in no event later than 120 days after such receipt. The decision of the Administrator shall be written and shall include specific reasons for the decision, written in a manner calculated

to be understood by the claimant, with specific references to the pertinent Plan provisions on which the decision is based.

(e) **Health FSA claims.** If a Participant fails to submit a claim under the Health Flexible Spending Account within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for the reimbursement must be submitted within 30 days after termination of employment. Once a claim is submitted, the following timetable for claims and rules below apply:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by Participant	45 days
Review of claim denial	60 days

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

- (1) The specific reason or reasons for the denial.
- (2) Reference to the specific Plan provisions on which the denial was based.
- (3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
- (4) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the right to bring a civil action under Section 502 of ERISA following a denial on review.
- (5) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.
- (6) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that

such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When the Participant receives a denial, the Participant shall have 180 days following receipt of the notification in which to appeal the decision. The Participant may submit written comments, documents, records, and other information relating to the Claim. If the Participant requests, the Participant shall be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

- (1) was relied upon in making the claim determination;
- (2) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;
- (3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- (4) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

(f) **Forfeitures.** Any balance remaining in the Participant's Health Flexible Spending Account (excluding any carryover) or Dependent Care Flexible Spending Account as of the end of the time for claims reimbursement for each Plan Year shall be forfeited and deposited in the benefit plan surplus of the Employer pursuant to Section 6.3 or Section 7.8, whichever is applicable, unless the Participant had made a claim for such Plan Year, in writing, which has been denied or is pending; in which event the amount of the claim shall be held in his account until the claim appeal procedures set forth above have been satisfied or the claim is paid. If any such claim is denied on appeal,

the amount held beyond the end of the Plan Year shall be forfeited and credited to the benefit plan surplus.

## **8.2 APPLICATION OF BENEFIT PLAN SURPLUS**

Any forfeited amounts credited to the benefit plan surplus by virtue of the failure of a Participant to incur a qualified expense or seek reimbursement in a timely manner may, but need not be, separately accounted for after the close of the Plan Year (or after such further time specified herein for the filing of claims) in which such forfeitures arose. In no event shall such amounts be carried over to reimburse a Participant for expenses incurred during a subsequent Plan Year for the same or any other Benefit available under the Plan (excepting any carryover); nor shall amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by Treasury regulations. Amounts in the benefit plan surplus shall be used to defray any administrative costs and experience losses or used to provide additional benefits under the Plan. No amounts attributable to the Health Savings Account shall be subject to the benefit plan surplus.

## **8.3 NAMED FIDUCIARY**

The Administrator shall be the named fiduciary pursuant to ERISA Section 402 and shall be responsible for the management and control of the operation and administration of the Plan.

## **8.4 GENERAL FIDUCIARY RESPONSIBILITIES**

The Administrator and any other fiduciary under ERISA shall discharge their duties with respect to this Plan solely in the interest of the Participants and their beneficiaries and

- (a) for the exclusive purpose of providing Benefits to Participants and their beneficiaries and defraying reasonable expenses of administering the Plan;
- (b) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and
- (c) in accordance with the documents and instruments governing the Plan insofar as such documents and instruments are consistent with ERISA.

## **8.5 NONASSIGNABILITY OF RIGHTS**

The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method, and shall not be subject to the rights of creditors, and any attempt to cause such right to be so subjected shall not be recognized, except to such extent as may be required by law.

## **ARTICLE IX ADMINISTRATION**

### **9.1 PLAN ADMINISTRATION**

The Employer shall be the Administrator, unless the Employer elects otherwise. The Employer may appoint any person, including, but not limited to, the Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing acceptance in writing (or such other form as acceptable to both parties) with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.

If the Employer elects, the Employer shall appoint one or more Administrators. Any person, including, but not limited to, the Employees of the Employer, shall be eligible to serve as an Administrator. Any person so appointed shall signify acceptance by filing acceptance in writing (or such other form as acceptable to both parties) with the Employer. An Administrator may resign by delivering a resignation in writing (or such other form as acceptable to both parties) to the Employer or be removed by the Employer by delivery of notice of removal (in writing or such other form as acceptable to both parties), to take effect at a date specified therein, or upon delivery to the Administrator if no date is specified. The Employer shall be empowered to appoint and remove the Administrator from time to time as it deems necessary for the proper administration of the Plan to ensure that the Plan is being operated for the exclusive benefit of the Employees entitled to participate in the Plan in accordance with the terms of the Act, the Plan and the Code.

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the Plan. The Administrator shall have full power and discretion to administer the Plan in all of its details and determine all questions arising in connection with the administration, interpretation, and application of the Plan. The Administrator may establish procedures, correct any defect, supply any information, or reconcile any inconsistency in such manner and to such extent as shall be deemed necessary or advisable to carry out the purpose of the Plan. The Administrator shall have all powers necessary or appropriate to accomplish the Administrator's duties under the Plan. The Administrator shall be charged with the duties of the general administration of the Plan as set forth under the Plan, including, but not limited to, in addition to all other powers provided by this Plan:

- (a) To make and enforce such procedures, rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;
- (b) To interpret the provisions of the Plan, the Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of the Plan;
- (c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan;

(d) To reject elections or to limit contributions or Benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;

(e) To provide Employees with a reasonable notification of their benefits available by operation of the Plan and to assist any Participant regarding the Participant's rights, benefits or elections under the Plan;

(f) To keep and maintain the Plan documents and all other records pertaining to and necessary for the administration of the Plan;

(g) To review and settle all claims against the Plan, to approve reimbursement requests, and to authorize the payment of benefits if the Administrator determines such shall be paid if the Administrator decides in its discretion that the applicant is entitled to them. This authority specifically permits the Administrator to settle disputed claims for benefits and any other disputed claims made against the Plan;

(h) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Section 609; and

(i) To appoint such agents, counsel, accountants, consultants, and other persons or entities as may be required to assist in administering the Plan.

Any procedure, discretionary act, interpretation or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with the terms of Code Section 125 and the Treasury regulations thereunder.

## **9.2 EXAMINATION OF RECORDS**

The Administrator shall make available to each Participant, Eligible Employee and any other Employee of the Employer such records as pertain to their interest under the Plan for examination at reasonable times during normal business hours.

## **9.3 PAYMENT OF EXPENSES**

Any reasonable administrative expenses shall be paid by the Employer unless the Employer determines that administrative costs shall be borne by the Participants under the Plan or by any Trust Fund which may be established hereunder. The Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of highly compensated employees.

#### **9.4 INSURANCE CONTROL CLAUSE**

In the event of a conflict between the terms of this Plan and the terms of an Insurance Contract of an independent third party Insurer whose product is then being used in conjunction with this Plan, the terms of the Insurance Contract shall control as to those Participants receiving coverage under such Insurance Contract. For this purpose, the Insurance Contract shall control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the benefits Participants are entitled to and the circumstances under which insurance terminates.

#### **9.5 INDEMNIFICATION OF ADMINISTRATOR**

The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who previously served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

### **ARTICLE X AMENDMENT OR TERMINATION OF PLAN**

#### **10.1 AMENDMENT**

The Employer, at any time or from time to time, may amend any or all of the provisions of the Plan without the consent of any Employee or Participant. No amendment shall have the effect of modifying any benefit election of any Participant in effect at the time of such amendment, unless such amendment is made to comply with Federal, state or local laws, statutes or regulations.

#### **10.2 TERMINATION**

The Employer reserves the right to terminate this Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made. Benefits under any Insurance Contract shall be paid in accordance with the terms of the Insurance Contract.

No further additions shall be made to the Health Flexible Spending Account or Dependent Care Flexible Spending Account, but all payments from such fund shall continue to be made according to the elections in effect until 90 days after the termination date of the Plan. Any amounts remaining in any such fund or account as of the end of such period shall be forfeited and deposited in the benefit plan surplus after the expiration of the filing period.

## **ARTICLE XI MISCELLANEOUS**

### **11.1 PLAN INTERPRETATION**

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in Section 11.12.

### **11.2 GENDER AND NUMBER**

Wherever any words are used herein in the masculine, feminine or neuter gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

### **11.3 WRITTEN DOCUMENT**

This Plan, in conjunction with any separate written document which may be required by law, is intended to satisfy the written Plan requirement of Code Section 125 and any Treasury regulations thereunder relating to cafeteria plans.

### **11.4 EXCLUSIVE BENEFIT**

This Plan shall be maintained for the exclusive benefit of the Employees who participate in the Plan.

### **11.5 PARTICIPANT'S RIGHTS**

This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge shall have upon him as a Participant of this Plan.

### **11.6 ACTION BY THE EMPLOYER**

Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by its legally constituted authority.



## **11.7 EMPLOYER'S PROTECTIVE CLAUSES**

(a) **Insurance purchase.** Upon the failure of either the Participant or the Employer to obtain the insurance contemplated by this Plan (whether as a result of negligence, gross neglect or otherwise), the Participant's Benefits shall be limited to the insurance premium(s), if any, that remained unpaid for the period in question and the actual insurance proceeds, if any, received by the Employer or the Participant as a result of the Participant's claim.

(b) **Validity of insurance contract.** The Employer shall not be responsible for the validity of any Insurance Contract issued hereunder or for the failure on the part of the Insurer to make payments provided for under any Insurance Contract. Once insurance is applied for or obtained, the Employer shall not be liable for any loss which may result from the failure to pay Premiums to the extent Premium notices are not received by the Employer.

## **11.8 NO GUARANTEE OF TAX CONSEQUENCES**

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

## **11.9 INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS**

If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted Benefit, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax (plus any penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

## **11.10 FUNDING**

Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit, but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit

of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

#### **11.11 GOVERNING LAW**

This Plan is governed by the Code and the Treasury regulations issued thereunder (as they might be amended from time to time). In no event shall the Employer guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of the State of Florida.

#### **11.12 SEVERABILITY**

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

#### **11.13 CAPTIONS**

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof.

#### **11.14 CONTINUATION OF COVERAGE (COBRA)**

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan subject to the continuation coverage requirement of Code Section 4980B becomes unavailable, each Participant will be entitled to continuation coverage as prescribed in Code Section 4980B, and related regulations. This Section shall only apply if the Employer employs at least twenty (20) employees on more than 50% of its typical business days in the previous calendar year.

#### **11.15 FAMILY AND MEDICAL LEAVE ACT (FMLA)**

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan shall be operated in accordance with Regulation 1.125-3.

#### **11.16 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)**

Notwithstanding anything in this Plan to the contrary, this Plan shall be operated in accordance with HIPAA and regulations thereunder.

## 11.17 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with the Uniform Services Employment And Reemployment Rights Act (USERRA) and the regulations thereunder.

## 11.18 COMPLIANCE WITH HIPAA PRIVACY STANDARDS

(a) **Application.** If any benefits under this Cafeteria Plan are subject to the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), then this Section shall apply.

(b) **Disclosure of PHI.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this Section are met. "Protected Health Information" shall have the same definition as set forth in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including genetic information and information about treatment or payment for treatment.

(c) **PHI disclosed for administrative purposes.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment functions and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care. Protected Health Information that consists of genetic information will not be used or disclosed for underwriting purposes.

(d) **PHI disclosed to certain workforce members.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan. "Members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer. The Employer shall keep an updated list of those authorized to receive Protected Health Information.

(1) An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(2) In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the Plan's privacy official. The privacy official shall take appropriate action, including:

(i) investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;

(iii) mitigation of any harm caused by the breach, to the extent practicable; and

(iv) documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(e) **Certification.** The Employer must provide certification to the Plan that it agrees to:

(1) Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;

(2) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(3) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(4) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law;

(5) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(6) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

- (7) Make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;
- (8) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
- (9) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- (10) Ensure the adequate separation between the Plan and members of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards and set out in (d) above.

#### **11.19 COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS**

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"):

- (a) **Implementation.** The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
- (b) **Agents or subcontractors shall meet security standards.** The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
- (c) **Employer shall ensure security standards.** The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Section 11.18.

#### **11.20 MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act and ERISA Section 712.

#### **11.21 GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act.

#### **11.22 WOMEN'S HEALTH AND CANCER RIGHTS ACT**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Women's Health and Cancer Rights Act of 1998.

#### **11.23 NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT**

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Newborns' and Mothers' Health Protection Act.

IN WITNESS WHEREOF, this Plan document is hereby executed this date:

---

**TAMPA BAY WORKFORCE ALLIANCE, INC. DBA  
CAREERSOURCE TAMPA BAY:**

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Title/Position: \_\_\_\_\_

# CAREERSOURCE TAMPA BAY

## FLEXIBLE SPENDING ACCOUNT

### SUMMARY PLAN DESCRIPTION

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#### **Plan Number 502**

Established as of **January 1, 2018**  
Amended and Restated as of **September 1, 2018**



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**XI  
SUMMARY**

# **CAREERSOURCE TAMPA BAY FLEXIBLE SPENDING ACCOUNT**

## **INTRODUCTION**

We have amended the "Flexible Benefits Plan" that we previously established for you and other eligible employees. Under this Plan, you will be able to choose among certain benefits that we make available. The benefits that you may choose are outlined in this Summary Plan Description. We will also tell you about other important information concerning the amended Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

One of the most important features of our Plan is that the benefits being offered are generally ones that you are already paying for, but normally with money that has first been subject to income and Social Security taxes. Under our Plan, these same expenses will be paid for with a portion of your pay before Federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

Read this Summary Plan Description carefully so that you understand the provisions of our amended Plan and the benefits you will receive. This SPD describes the Plan's benefits and obligations as contained in the legal Plan document, which governs the operation of the Plan. The Plan document is written in much more technical and precise language. If the non-technical language in this SPD and the technical, legal language of the Plan document conflict, the Plan document always governs. Also, if there is a conflict between an insurance contract and either the Plan document or this Summary Plan Description, the insurance contract will control. If you wish to receive a copy of the legal Plan document, please contact the Administrator.

This SPD describes the current provisions of the Plan which are designed to comply with applicable legal requirements. The Plan is subject to federal laws, such as the Internal Revenue Code and other federal and state laws which may affect your rights. The provisions of the Plan are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or other federal agencies. We may also amend or terminate this Plan. If the provisions of the Plan that are described in this SPD change, we will notify you.

We have attempted to answer most of the questions you may have regarding your benefits in the Plan. If this SPD does not answer all of your questions, please contact the Administrator (or other plan representative). The name and address of the Administrator can be found in the Article of this SPD entitled "General Information About the Plan."

## **I ELIGIBILITY**

### **1. When can I become a participant in the Plan?**

Before you become a Plan member (referred to in this Summary Plan Description as a "Participant"), there are certain rules which you must satisfy. First, you must meet the eligibility requirements and be an active employee. After that, the next step is to actually join the Plan on the "entry date" that we have established for all employees. The "entry date" is defined in Question 3 below. You will also be required to complete certain application forms before you can enroll in the Plan.

## **2. What are the eligibility requirements for our Plan?**

You will be eligible to join the Plan once you have completed 30 days of employment. Of course, if you were already a participant before this amendment, you will remain a participant.

## **3. When is my entry date?**

Once you have met the eligibility requirements, your entry date will be the first day of the month following the date you met the eligibility requirements.

## **4. Are there any employees who are not eligible?**

Yes, there are certain employees who are not eligible to join the Plan. They are:

-- Employees who are part-time. A part-time employee is someone who works, or is expected to work, less than 30 hours a week.

## **5. What must I do to enroll in the Plan?**

Before you can join the Plan, you must complete an application to participate in the Plan. The application includes your personal choices for each of the benefits which are being offered under the Plan. You must also authorize us to set some of your earnings aside in order to pay for the benefits you have elected.

## **II OPERATION**

### **1. How does this Plan operate?**

Before the start of each Plan Year, you will be able to elect to have some of your upcoming pay contributed to the Plan. These amounts will be used to pay for the benefits you have chosen. The portion of your pay that is paid to the Plan is not subject to Federal income or Social Security taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses which you normally pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a Federal income tax credit or deduction on your return. (See the Article entitled "General Information About Our Plan" for the definition of "Plan Year.")

## **III CONTRIBUTIONS**

### **1. How much of my pay may the Employer redirect?**

Each year, you may elect to have us contribute on your behalf enough of your compensation to pay for the benefits that you elect under the Plan. These amounts will be deducted from your pay over the course of the year.

## **2. What happens to contributions made to the Plan?**

Before each Plan Year begins, you will select the benefits you want and how much of the contributions should go toward each benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year. Later, they will be used to pay for the expenses as they arise during the Plan Year.

## **3. When must I decide which accounts I want to use?**

You are required by Federal law to decide before the Plan Year begins, during the election period (defined below). You must decide two things. First, which benefits you want and, second, how much should go toward each benefit.

## **4. When is the election period for our Plan?**

You will make your initial election on or before your entry date. (You should review Section I on Eligibility to better understand the eligibility requirements and entry date.) Then, for each following Plan Year, the election period is established by the Administrator and applied uniformly to all Participants. It will normally be a period of time prior to the beginning of each Plan Year. The Administrator will inform you each year about the election period. (See the Article entitled "General Information About Our Plan" for the definition of Plan Year.)

## **5. May I change my elections during the Plan Year?**

Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections. You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the change in status. Currently, Federal law considers the following events to be a change in status:

- Marriage, divorce, death of a spouse, legal separation or annulment;
- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;
- Any of the following events for you, your spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;
- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance; and
- A change in the place of residence of you, your spouse or dependent that would lead to a change in status, such as moving out of a coverage area for insurance.

In addition, if you are participating in the Dependent Care Flexible Spending Account, then there is a change in status if your dependent no longer meets the qualifications to be eligible for dependent care.

However, with respect to the Health Savings Account, you may modify or revoke your elections without having to have a change in status.

There are detailed rules on when a change in election is deemed to be consistent with a change in status. In addition, there are laws that give you rights to change health coverage for you, your spouse, or your dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Administrator within 30 days of the event causing the change in status, unless the law grants you more time. See your Administrator for more details.

If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then we will automatically increase or decrease, as the case may be, your salary redirection election. If the cost increases significantly, you will be permitted to either make corresponding changes in your payments or revoke your election and obtain coverage under another benefit package option with similar coverage, or revoke your election entirely.

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, then you may revoke your elections and elect to receive on a prospective basis coverage under another plan with similar coverage. In addition, if we add a new coverage option or eliminate an existing option, you may elect the newly-added option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar coverage. If you are not a Participant, you may elect to join the Plan. There are also certain situations when you may be able to change your elections on account of a change under the plan of your spouse's, former spouse's or dependent's employer.

These rules on change due to cost or coverage do not apply to the Health Flexible Spending Account, and you may not change your election to the Health Flexible Spending Account if you make a change due to cost or coverage for insurance or if you decide to participate in the Health Savings Account.

You may not change your election under the Dependent Care Flexible Spending Account if the cost change is imposed by a dependent care provider who is your relative.

You may revoke your coverage under the employer's group health plan outside of our open enrollment period, if your employment status changes from working at least 30 hours per week to less than 30 hours. This is regardless of whether the reduction in hours has resulted in loss of eligibility. You must show intent to enroll in another health plan.

You may also revoke your coverage under our Employer sponsored group health plan if you are eligible to obtain coverage through the health exchanges.

## **6. May I make new elections in future Plan Years?**

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the election period before a new Plan Year begins, we will consider that to mean you have elected not to participate for the upcoming Plan Year.

## IV BENEFITS

### 1. Health Flexible Spending Account

The Health Flexible Spending Account enables you to pay for expenses allowed under Sections 105 and 213(d) of the Internal Revenue Code which are not covered by our insured medical plan and save taxes at the same time. The Health Flexible Spending Account allows you to be reimbursed by the Employer for expenses incurred by you and your dependents.

If you contribute to the Health Flexible Spending Account, you will not be eligible to make contributions to a Health Savings Account during the entire Plan Year of the Health Flexible Spending Account without consideration of the amount available in the Health Flexible Spending Account for any month during the Plan Year. This means that if you are covered by the Health Flexible Spending Account because of a carryover of unused amounts, you may not contribute to a Health Savings Account, even for months in the Plan Year after the Health Flexible Spending Account no longer has any amounts available to pay or reimburse medical expenses.

Drug costs, including insulin, may be reimbursed.

You may be reimbursed for "over the counter" drugs only if those drugs are prescribed for you. You may not, however, be reimbursed for the cost of other health care coverage maintained outside of the Plan, or for long-term care expenses. A list of covered expenses is available from the Administrator.

The most that you can contribute to your Health Flexible Spending Account each Plan Year is \$2,650 for 2018. After 2018, the dollar limit may increase for cost of living adjustments. In addition, you will be eligible to carryover amounts left in your Health Flexible Spending Account, up to \$500. This means that amounts you do not use during a Plan Year can be carried over to the next Plan Year and used for expenses incurred in the next Plan Year.

In order to be reimbursed for a health care expense, you must submit to the Administrator an itemized bill from the service provider. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. Reimbursement from the fund shall be paid at least once a month. Expenses under this Plan are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged, or you pay for the medical care.

You may be reimbursed for expenses for any child until the end of the calendar year in which the child reaches age 26. A child is a natural child, stepchild, foster child, adopted child, or a child placed with you for adoption. If a child gains or regains eligibility due to these new rules, that qualifies as a change in status to change coverage.

Newborns' and Mothers' Health Protection Act: Group health plans 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).



Women's Health and Cancer Rights Act: This plan, as required by the Women's Health and Cancer Rights Act of 1998, will reimburse up to plan limits for benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Contact your Plan Administrator for more information.

## **2. Dependent Care Flexible Spending Account**

The Dependent Care Flexible Spending Account enables you to pay for out-of-pocket, work-related dependent day-care cost with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single employees can also use the account.

An eligible dependent is someone for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Dependent Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent Care arrangements which qualify include:

- (a) A Dependent (Day) Care Center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws;
- (b) An Educational Institution for pre-school children. For older children, only expenses for non-school care are eligible; and
- (c) An "Individual" who provides care inside or outside your home: The "Individual" may not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes.

You should make sure that the dependent care expenses you are currently paying for qualify under our Plan.

The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Flexible Spending Account. Generally, your reimbursements may not exceed the lesser of: (a) \$5,000 (if you are married filing a joint return or you are head of a household) or \$2,500 (if you are married filing separate returns); (b) your taxable compensation; (c) your spouse's actual or deemed earned income (a spouse who is a full time student or incapable of caring for himself/herself has a monthly earned income of \$250 for one dependent or \$500 for two or more dependents).

Also, in order to have the reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In addition, Federal tax laws permit a tax credit for certain dependent care expenses you may be paying for even if you are not a Participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Flexible Spending Account under our Plan. Ask your tax adviser which is better for you.

### **3. Premium Expense Account**

A Premium Expense Account allows you to use tax-free dollars to pay for certain premium expenses under various insurance programs that we offer you. These premium expenses include:

- Health care premiums under our insured group medical plan.
- Dental insurance premiums.
- Vision insurance premiums.
- Specified voluntary worksite insurance premiums.

Under our Plan, we will establish sub-accounts for you for each different type of insurance coverage that is available. Also, certain limits on the amount of coverage may apply.

The Administrator may terminate or modify Plan benefits at any time, subject to the provisions of any insurance contracts providing benefits described above. We will not be liable to you if an insurance company fails to provide any of the benefits described above. Also, your insurance will end when you leave employment, are no longer eligible under the terms of any insurance policies, or when insurance terminates.

Any benefits to be provided by insurance will be provided only after (1) you have provided the Administrator the necessary information to apply for insurance, and (2) the insurance is in effect for you.

If you cover your children up to age 26 under your insurance, you can pay for that coverage through the Plan.

### **4. May I direct Plan contributions to my Health Savings Account?**

Yes. Any monies that you do not apply toward available benefits can be contributed to your Health Savings Account, which enables you to pay for expenses which are not covered by our insured medical plan and save taxes at the same time. The maximum amount you may contribute to a Health Savings Account during a calendar year is established by the Internal Revenue Service (IRS), and is adjusted by the IRS from time to time. The maximum contributions that are allowable under this plan during any calendar year will automatically be adjusted to the maximum contribution amounts set by the IRS. If you contribute to the Health Flexible Spending Account, you may not direct contributions to a Health Savings Account. Please see your Plan Administrator for further details.

## **V**

### **BENEFIT PAYMENTS**

#### **1. When will I receive payments from my accounts?**

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements which are made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes. Requests for payment of insured benefits should be made directly to the insurer.

You will only be reimbursed from the Dependent Care Flexible Spending Account to the extent that there are sufficient funds in the Account to cover your request.

## **2. What happens if I don't spend all Plan contributions during the Plan Year?**

Any monies left at the end of the Plan Year will be forfeited, except for \$500 that can be carried over into the next Plan Year for the Health Flexible Spending Account or, except for amounts contributed to your Health Savings Account. Obviously, qualifying expenses that you incur late in the Plan Year for which you seek reimbursement after the end of such Plan Year will be paid first before any amount is forfeited. For the Health Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. For the Dependent Care Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

## **3. Family and Medical Leave Act (FMLA)**

If you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections for health insurance and the Health Flexible Spending Account. If your coverage in these benefits terminates, due to your revocation of the benefit while on leave or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return. For the Health Flexible Spending Account, you may continue your coverage or you may revoke your coverage and resume it when you return. You can resume your coverage at its original level and make payments for the time that you are on leave. For example, if you elect \$1,200 for the year and are out on leave for 3 months, then return and elect to resume your coverage at that level, your remaining payments will be increased to cover the difference - from \$100 per month to \$150 per month. Alternatively your maximum amount will be reduced proportionately for the time that you were gone. For example, if you elect \$1,200 for the year and are out on leave for 3 months, your amount will be reduced to \$900. The expenses you incur during the time you are not in the Health Flexible Spending Account are not reimbursable.

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage, you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to "catch up" your payments when you return.

## **4. Uniformed Services Employment and Reemployment Rights Act (USERRA)**

If you are going into or returning from military service, you may have special rights to health care coverage under your Health Flexible Spending Account under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask your Administrator for further details.

## **5. What happens if I terminate employment?**

If you terminate employment during the Plan Year, you will lose coverage per the timeframe determined in the underlying documents for each benefit. Your right to benefits will be determined in the following manner:

- (a) You will remain covered by insurance, but only for the period for which premiums have been paid prior to your termination of employment.
- (b) You will still be able to request reimbursement for qualifying dependent care expenses incurred prior to your date of termination from the balance remaining in your dependent care account at the time of termination of employment. However, no further salary redirection contributions will be made on your behalf after you terminate. You must submit claims within 30 days after termination.
- (c) Your Health Savings Account amounts will remain yours even after your termination of employment.
- (d) For health benefit coverage and Health Flexible Spending Account coverage on termination of employment, please see the Article entitled "Continuation Coverage Rights Under COBRA." Upon your termination of employment, your participation in the Health Flexible Spending Account will cease, and no further salary redirection contributions will be contributed on your behalf. However, you will be able to submit claims for health care expenses that were incurred prior to midnight of the date of termination, provided that you submit these claims within 30 days following the date of termination. Your further participation will be governed by "Continuation Coverage Rights Under COBRA." Your further participation will be governed by "Continuation Coverage Rights Under COBRA."

## **6. Will my Social Security benefits be affected?**

Your Social Security benefits may be slightly reduced because when you receive tax-free benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as our contribution to Social Security on your behalf.

# **VI HIGHLY COMPENSATED AND KEY EMPLOYEES**

## **1. Do limitations apply to highly compensated employees?**

Under the Internal Revenue Code, highly compensated employees and key employees generally are Participants who are officers, shareholders or highly paid. You will be notified by the Administrator each Plan Year whether you are a highly compensated employee or a key employee.

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the key employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under our Plan.

Plan experience will dictate whether contribution limitations on highly compensated employees or key employees will apply. You will be notified of these limitations if you are affected.

## **VII PLAN ACCOUNTING**

### **1. Periodic Statements**

The Administrator will provide you with a statement of your account periodically during the Plan Year that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year.

## **VIII GENERAL INFORMATION ABOUT OUR PLAN**

This Section contains certain general information which you may need to know about the Plan.

### **1. General Plan Information**

CareerSource Tampa Bay Flexible Spending Account is the name of the Plan.

Your Employer has assigned Plan Number 502 to your Plan.

The provisions of your amended Plan become effective on September 1, 2018. Your Plan was originally effective on January 1, 2018.

Your Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on January 1 and ends on December 31.

### **2. Employer Information**

Your Employer's name, address, and identification number are:

Tampa Bay Workforce Alliance, Inc. DBA CareerSource Tampa Bay  
4902 Eisenhower Blvd., Suite 250  
Tampa, Florida 33634  
59-3655316

### **3. Plan Administrator Information**

The name, address and business telephone number of your Plan's Administrator are:

Tampa Bay Workforce Alliance, Inc. DBA CareerSource Tampa Bay  
4902 Eisenhower Blvd., Suite 250  
Tampa, Florida 33634  
813-930-7400

The Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about our Plan. You may contact the Administrator for any further information about the Plan.

#### **4. Service of Legal Process**

The name and address of the Plan's agent for service of legal process are:

Tampa Bay Workforce Alliance, Inc. DBA CareerSource Tampa Bay  
4902 Eisenhower Blvd., Suite 250  
Tampa, Florida 33634

#### **5. Type of Administration**

The type of Administration is Employer Administration.

#### **6. Claims Submission**

Claims for expenses should be submitted to:

Tampa Bay Workforce Alliance, Inc. DBA CareerSource Tampa Bay  
4902 Eisenhower Blvd., Suite 250  
Tampa, Florida 33634

### **IX ADDITIONAL PLAN INFORMATION**

#### **1. Your Rights Under ERISA**

Plan Participants, eligible employees and all other employees of the Employer may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. For those benefits subject to ERISA, these laws provide that Participants, eligible employees and all other employees are entitled to:

- (a) examine, without charge, at the Administrator's office, all Plan documents, including insurance contracts, 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;
- (b) obtain copies of all Plan documents and other Plan information upon written request to the Administrator. The Administrator may charge a reasonable fee for the copies;
- (c) continue health coverage for a Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents may have to pay for such coverage; and
- (d) review this summary plan description and the documents governing the plan on the rules governing COBRA continuation rights.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Plan Participants.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

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 thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the 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 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, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about the Plan, you should contact the Administrator. If you have any questions about this statement, or about your rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA) or if you need assistance in obtaining documents from the Administrator, you should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at [www.dol.gov/ebsa/](http://www.dol.gov/ebsa/). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## **2. Claims Process**

You should submit all reimbursement claims during the Plan Year. For the Health Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. However, if you terminate employment during the Plan Year, you must submit your Health Flexible Spending Account claims within 30 days after your termination of employment. For the Dependent Care Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. However, if you terminate employment during the Plan Year, you must submit your Dependent Care Flexible Spending Account claims within 30 days after your termination of employment. Any claims submitted after that time will not be considered.

Claims that are insured will be handled in accordance with procedures contained in the insurance policies. All other general requests should be directed to the Administrator of our Plan. If a dependent care claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. Within 60 days after denial, you or your beneficiary may submit a written request for reconsideration of the denial to the Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended an additional 60 days under certain circumstances.) In this response, the Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding.

In the case of a claim for medical expenses under the Health Flexible Spending Account, the following timetable for claims applies:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information to process the claim:	
Notification to Participant	15 days
Response by Participant	45 days
Review of claim denial	60 days

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

- (a) The specific reason or reasons for the denial;
- (b) Reference to the specific Plan provisions on which the denial was based;
- (c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- (d) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under section 502 of ERISA following a denial on review;
- (e) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and
- (f) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.



The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

- (a) was relied upon in making the claim determination;
- (b) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;
- (c) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- (d) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

### **3. Qualified Medical Child Support Order**

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a participant. The child becomes an "alternate recipient" and can receive benefits under the health plans of the Employer, if the order is determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Plan Administrator.

## **X CONTINUATION COVERAGE RIGHTS UNDER COBRA**

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain employees and their families covered under health benefits under this Plan will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator or its designee is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA. While the Plan itself is not a group health plan, it does provide health

benefits. Whenever "Plan" is used in this section, it means any of the health benefits under this Plan including the Health Flexible Spending Account.

## **1. What is COBRA continuation coverage?**

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

There may be other options available 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.

## **2. Who can become a Qualified Beneficiary?**

In general, a Qualified Beneficiary can be:

(a) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(b) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan. However, this provision does not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or

Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

### **3. What is a Qualifying Event?**

A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- (a) The death of a covered Employee.
- (b) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- (c) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.
- (d) A covered Employee's enrollment in any part of the Medicare program.
- (e) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993, as amended ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

#### 4. What factors should be considered when determining to elect COBRA continuation coverage?

When considering options for health coverage, Qualified Beneficiaries should consider:

- **Premiums**: This plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive. Qualified Beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's employer) within 30 days after Plan coverage ends due to one of the Qualifying Events listed above.
- **Provider Networks**: If a Qualified Beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care provider. You may want to check to see if your current health care providers participate in a network in considering options for health coverage.
- **Drug Formularies**: For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication – and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.
- **Severance payments**: If COBRA rights arise because the Employee has lost his job and there is a severance package available from the employer, the former employer may have offered to pay some or all of the Employee's COBRA payments for a period of time. This can affect the timing of coverage available in the Marketplace. In this scenario, the Employee may want to contact the Department of Labor at 1-866-444-3272 to discuss options.
- **Medicare Eligibility**: You should be aware of how COBRA coverage coordinates with Medicare eligibility. If you are eligible for Medicare at the time of the Qualifying Event, or if you will become eligible soon after the Qualifying Event, you should know that you have 8 months to enroll in Medicare after your employment –related health coverage ends. Electing COBRA coverage does not extend this 8-month period. For more information, see [medicare.gov/sign-up-change-plan](http://medicare.gov/sign-up-change-plan).
- **Service Areas**: If benefits under the Plan are limited to specific service or coverage areas, benefits may not be available to a Qualified Beneficiary who moves out of the area.
- **Other Cost-Sharing**: In addition to premiums or contributions for health coverage, the Plan requires participants to pay copayments, deductibles, coinsurance, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

**Are there other coverage options besides COBRA Continuation Coverage?** Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

**5. What is the procedure for obtaining COBRA continuation coverage?**

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

**6. What is the election period and how long must it last?**

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, as extended by the Trade Preferences Extension Act of 2015, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he or she and/or his or her family members may qualify for assistance under this special provision should contact the Plan Administrator or its designee for further information about the special second election period. If continuation coverage is elected under this extension, it will not become effective prior to the beginning of this special second election period.

**7. Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?**

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- (a) the end of employment or reduction of hours of employment,
- (b) death of the employee,
- (c) commencement of a proceeding in bankruptcy with respect to the Employer, or
- (d) entitlement of the employee to any part of Medicare.

**IMPORTANT:**

**For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during**

**the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator or its designee.**

***NOTICE PROCEDURES:***

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Tampa Bay Workforce Alliance, Inc. DBA CareerSource Tampa Bay  
4902 Eisenhower Blvd., Suite 250  
Tampa, Florida 33634

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives ***timely notice*** that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

**8. Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?**

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

**9. Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?**

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

#### **10. When may a Qualified Beneficiary's COBRA continuation coverage be terminated?**

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- (a) The last day of the applicable maximum coverage period.
- (b) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (c) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.
- (d) The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).
- (e) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
  - (1) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
  - (2) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

#### **11. What are the maximum coverage periods for COBRA continuation coverage?**

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

- (a) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(b) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries ends on the later of:

(1) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or

(2) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(c) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(d) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

## **12. Under what circumstances can the maximum coverage period be expanded?**

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

## **13. How does a Qualified Beneficiary become entitled to a disability extension?**

A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

## **14. Does the Plan require payment for COBRA continuation coverage?**

For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. Your Plan Administrator will inform you of the cost. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.



**15. Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?**

Yes. The Plan is also permitted to allow for payment at other intervals.

**16. What is Timely Payment for COBRA continuation coverage?**

Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

**17. Must a Qualified Beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?**

If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

**18. How is my participation in the Health Flexible Spending Account affected?**

You can elect to continue your participation in the Health Flexible Spending Account for the remainder of the Plan Year, subject to the following conditions. You may only continue to participate in the Health Flexible Spending Account if you have elected to contribute more money including any carryover amounts than you have taken out in claims. For example, if you elected to contribute an annual amount of \$500 and, at the time you terminate employment, you have contributed \$300 but only claimed \$150, you may elect to continue coverage under the Health Flexible Spending Account. If you elect to continue coverage, then you would be able to continue to receive your health reimbursements up to the \$500. However, you must continue to pay for the coverage, just as the money has been taken out of your paycheck, but on an after-tax basis. The Plan can also charge you an extra amount (as explained above for other health benefits) to provide this benefit.

## **IF YOU HAVE QUESTIONS**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified above. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov).

## **KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES**

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or its designee.

## **XI SUMMARY**

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities and save for the future. Our flexible benefits plan will help you keep more of the money you earn by lowering the amount of taxes you pay. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings.

If you have any questions, please contact the Administrator.