CareerSource TAMPA BAY

**Thursday, January 17, 2019, 11:00 AM**
9215 N. Florida Ave., Tampa, FL

# Board of Directors
## Agenda

I. **Welcome and Roll Call** ..... Sean Butler, Chair

II. **Public Comments**

III. **Presentation:** Investigation of Complaints ..... David Adams/Charley Harris

IV. **Approval of Minutes**
1) Nov 15, 2018 Board of Directors Meeting ..... Page 2
2) Dec 20, 2018 Special Board of Directors Meeting ..... Page 4

V. **Consent Agenda**
1) Consent Agenda of December 13, 2018 Executive Committee Meeting ..... Page 6

VI. **Chair's Report** ..... Sean Butler
1) Workforce Focus
2) February 6, 2019 Welcome Reception for John Flanagan
3) Internal Control Questionnaire ..... Sean Butler, Juditte Dorcy, Anna Munro
4) National Association of Workforce Boards (NAWB) Forum

VII. **Interim Executive Director's Report** ..... Juditte Dorcy
1) Update on DOL/DEO Review
2) Staff Training ..... Page 8
3) Programs Update
4) Upcoming Annual Performance Presentation by DEO
5) Upcoming DEO Audit Schedule ..... Page 9

VIII. **Action/Discussion Items**
1) Related Party Contracts ..... Juditte Dorcy, Page 10
2) Agreement with HCC to provide Career Ready programs ..... Michelle Schultz, Page 12
3) Business Association Program ..... Juditte Dorcy, Page 13
4) Form 550 Wrap Documents ..... Mimi Tran, Anna Munro, Page 14

IX. **Committee Reports**
1) Finance Committee ..... Sophia West
2) One Stop Committee ..... Mike Smith
   a. Presentation: One Stop Partners Portal ..... Dan McGrew, Page 55

X. **Adjournment**

Next Board of Directors Meeting: March 21, 2019
Next Executive Committee Meeting: February 21, 2019
Next Workforce Solutions Committee Meeting: February 13, 2019
Next One Stop Committee Meeting: February 20, 2019

# CareerSource Tampa Bay
# Meeting of the Board of Directors

**Date:** November 15, 2018, 11:00 a.m.
**Location:** 9215 N. Florida Ave., Ste. 101, Tampa, FL

**Call to Order**
Chair Sean Butler called the meeting to order at 11:05 a.m. There was a quorum present with the following Board Members participating.

**Board Members in attendance**
Tom Aderhold, Michael Bach, Leerone Benjamin, Stephanie Brown-Gilmore, Sean Butler, Ginger Clark, Richard Cranker, Elizabeth Gutierrez, Randall Hassen, Benjamin Hom, John Howell, Lindsey Kimball, Cally Kushmer, Jasiel Legon, April May, Commissioner Sandra Murman, Don Noble, Michael Ramsey, Yanina Rosario, Jeffrey Serpico, Michael Smith, Roy Sweatman, Sophia West

**Board Members not in attendance**
Michelle Calhoun, Judson Cook, Robert Coppersmith, Gail Fitzsimmons, Mireya Hernandez, Randall King, Paul Orvosh, Earl Rahn, Suzanne Skiratko

**Staff Present**
Juditte Dorcy, Jody Toner, Sheila Doyle, Anna Munro, Mimi Tran, Michelle Schultz, Mai Russell, Joe Vitale, Al Pierluissi

**Board Counsel**
Kelly Ruoff

**BOCC Liaison**
Kenneth Jones

**Others**
Steve Morey

The items are listed in the order of discussion.
►Indicates Board Action

**Public Comment**
There was none.

**Presentation: Connecting Economic Development with Workforce Services**
Steve Morey, Tampa Hillsborough Economic Development Corporation's SVP of Business Development spoke on the ongoing partnership with CareerSource Tampa Bay. Responding to the Board's inquiry on how to better improve the partnership, Mr. Morey responded having a representative from CareerSource Tampa Bay at the meetings with prospective businesses considering to relocate to the Tampa Bay region. He added the following factors are critical in attracting new businesses to the area: Quality of life, transportation, workforce availability, cost of living, pipeline of talents, and land resources.

**► Approval of Minutes**
A motion **to approve the minutes of September 20, 2018 Board of Directors meeting** was made by Richard Cranker and seconded by John Howell. There was no further discussion. The motion passed unanimously.

**► Consent Agenda**
A motion **to approve the consent agenda of October 18, 2018 Executive Committee meeting** was made by Benjamin Hom and Jeff Serpico. There was no further discussion. The motion passed unanimously.

A motion **to approve the 2018 – 19 Budget Modification No. 2** made by Sophia West and Roy Sweatman. The motion passed unanimously.

**Chair's Report**

Workforce Focus

Chairman Butler reported a job fair dedicated for veterans entitled Paychecks for Patriots was held on Nov 7th. Over 150 veterans attended to connect with 33 employers.

Internal Control Questionnaire

Chairman Butler stated the Internal Control Questionnaire is to be signed by the Board Chair.

Bylaws Revision

Chairman Butler reported the bylaws will be updated. Specific items for update include: Consolidating Audit & Finance Committee and Consent Agenda.

**Committee Reports**

**Executive Committee**

As an update on the CEO Search, a face-to-face interview will be held on Nov 29th & Nov 30th. Chairman Butler thanked BOCC Liaison Kenneth Jones for his assistance.

**Finance Committee**

Supportive Services Update

Staff researched into alternatives for supportive services items. For gas cards, only Speedway-issued gas cards that are limited to fuel only. For bus passes, HART offers various passes.

Third Party Contracts

A listing of third party contracts was provided in the meeting packet.

Internal & External Financial Audits

A schedule of financial audits conducted by DEO & external auditors was provided in the meeting packet.

Expenditures Report

CFO Doyle referred members' attention to the expenditures report. As of September 30th, CareerSource Tampa Bay has expended 15% of its budgets.

**One Stop Committee**

Performance Dashboard

Director Toner referred members' attention to the one-page performance dashboard. She added the data provided is a real-time data. Additional data will be added in the future.

WIOA Primary Indicators of Performance

Director Toner reported CareerSource Tampa Bay has exceeded all 8 performance measures for WIOA Adult, Dislocated Workers, and Youth; and all three measures for Wagner Peyser. She added quarter one performance for program year 2018 – 19 will be released in December.

**Workforce Solutions Committee**

Workforce Committee Chair Serpico reported the committee discussed modifying the policy for approving training vendors. The new policy shall be in effect beginning July 1, 2019.

**Adjournment**

The meeting was adjourned at approximately 12:45 p.m.

# CareerSource Tampa Bay
# Special Meeting of the Board of Directors

**Date:** December 20, 2018, 11:00 a.m.
**Location:** 9215 N. Florida Ave., Ste. 101, Tampa, FL

**Call to Order**
Chair Sean Butler called the meeting to order at 11:00 a.m. There was a quorum present with the following Board Members participating.

**Board Members in attendance**
Michael Bach, Leerone Benjamin, Stephanie Brown-Gilmore, Sean Butler, Michelle Calhoun, Ginger Clark, Robert Coppersmith, Elizabeth Gutierrez, John Howell, Lindsey Kimball, Randall King, Cally Kushmer, Jasiel Legon, April May, Commissioner Sandra Murman, Don Noble, Jeffrey Serpico, Michael Smith, Roy Sweatman, Sophia West

**Board Members not in attendance**
Tom Aderhold, Judson Cook, Richard Cranker, Gail Fitzsimmons, Randall Hassen, Benjamin Hom, Mireya Hernandez, Paul Orvosh, Earl Rahn, Michael Ramsey, Yanina Rosario, Suzanne Skiratko

**Staff Present**
Juditte Dorcy, Jody Toner, Sheila Doyle, Anna Munro, Mimi Tran, Michelle Schultz, Mai Russell, Doug Tobin, Joe Vitale, Al Pierluissi

**Board Counsel**
Charley Harris

**BOCC Liaison**
Kenneth Jones, Ron Barton

**Others**
Teri Morrow, Krystyn Brendle, Nathan Dundes, John Flanagan

►Indicates Board Action

**Public Comment**
There was none.

**Approval of Incoming CEO for CareerSource Tampa Bay**
Chairman Butler introduced HR Consultant Teri Morrow of My Benefits Partner. She introduced her team, Kristyn Brendle and Nathan Dundes, who assisted with facilitating the CEO recruitment.

She spoke on the process and outlined the steps taken beginning with drafting the CEO job description. Upon approval by the CEO Search Committee, the job description was posted to online job boards, including Employ Florida, Indeed, and Monster. In response, 314 applications/résumés were received.

Out of those, My Benefits Partner identified 43 candidates that met with the minimum qualifications. A 20- to 30-minute telephone interview was conducted for each of the 43 candidates. The telephone interviews consisted of 19 behavioral interview questions and a scoring matrix, both of which were approved by the Search Committee.

Of those 43 candidates, My Benefits Partner identified the top 15 candidates that scored the highest, then submitted the analysis including the top 15 candidates' application/résumés, telephone interview notes and scoring matrices to the CEO Search Committee for their review. The results of the telephone interview were then presented to the Executive/CEO Search Committee.

Each Executive/CEO Search Committee member conducted its independent review of those 15 candidates and forwarded his/her top candidate selection to My Benefits Partner. My Benefits Partner

then calculated the committee members' selections and created an analysis of the top candidates, as selected by the CEO Search Committee. My Benefits Partner then presented the top 15 candidate selection analysis to the CEO Search Committee for their review and discussion.

Out of the 15 candidates, the CEO Search Committee unanimously agreed to meet with top 6 candidates for a face-to-face interview. My Benefit Partners drafted 13 questions and a scoring matrix for the face-to-face interviews that were reviewed and approved by the CEO Search Committee.

After the face-to-face interviews with top 6 candidates concluded, the committee members reviewed their notes, discussed each candidate, and voted on the top two candidates. The top two candidates were asked to complete the Omnia behavioral assessment. The results of the evaluation were presented to the CEO Search Committee for their consideration. After discussion, the Executive/CEO Search Committee unanimously voted on one final candidate for presentation to the full Board of Directors for their approval.

Chairman Butler then introduced the final candidate, John Flanagan, who shared his 15 years of workforce development experience working in various roles beginning with serving as a contractor managing the Adult, Dislocated Worker, and Youth programs. He stressed the importance of workforce development in fostering economic development. He said there are many opportunities in serving the small businesses in this region. His experience also included working in a newly designated WIOA area in Colorado that included creating policies, helping the commissioners build the Board of Directors, and get the programs up and running. While in Colorado, he had some great success in generating other revenues. He then moved to Pennsylvania to run the workforce board in Bucks County.

[John Flanagan left the meeting room.]

Chairman Butler then opened the floor for discussion. He thanked HR Consultant Teri Morrow and her team for their good work. He thanked Juditte Dorcy for her strong performance throughout the interview process.

►**A motion to approve John Flanagan as the CEO and appoint Juditte Dorcy as the Chief Operating Officer** was made by Commissioner Sandra Murman and seconded by Randall King. There was no further discussion. The motion carried unanimously.

Chairman Butler reported John Flanagan has accepted the conditional offer. His start date will be towards the end of January. Charley Harris will draft his employment contract. Juditte Dorcy will serve as the Interim CEO until John Flanagan's start date. John Flanagan's salary shall be $160K, and his relocation reimbursement shall not exceed $10K.

Hillsborough County Ron Barton thanked all board members for their support these past several months and the County appreciates their support. Commissioner Murman thanked Kenneth Jones for his assistance, guidance, and leadership. Doug Tobin, Communications Coordinator, will prepare the press release.

BOCC Liaison Kenneth Jones suggested introducing John Flanagan at the upcoming BOCC meeting. Commissioner Murman suggested hosting a welcome reception for John Flanagan to meet with community partners.

[John Flanagan returned.]

Speaking to John Flanagan, Chairman Butler summarized his compensation and the immediate next steps to be taken to bring him onboard.

**Adjournment**
The meeting was adjourned at approximately 11:35 a.m.

**CareerSource Tampa Bay**
**Consent Agenda of December 13, 2018 Executive Committee Meeting**

**Actions Approved At CareerSource Tampa Bay Executive Committee Meeting**
*Any Board Member shall have five days from receipt of these minutes within which to request that an action of the Executive Committee be brought before the full Board. If no such request is made, the actions of the Executive Committee shall stand.*

**Date:** December 13, 2018, 11:00 a.m.
**Location:** CareerSource Tampa Bay Center, 9215 N. Florida Ave., Ste. 101, Tampa, FL

**Call to Order**
Chair Sean Butler called the meeting to order at 11:03 a.m. There was a quorum present with the following Executive Committee members participating.

**Members in attendance**
Sean Butler, Ginger Clark, Randall King, Commissioner Sandra Murman, Jeffrey Serpico, Roy Sweatman, Sophia West

**Not in attendance**
Mike Smith

**Staff Present**
Juditte Dorcy (via telephone), Sheila Doyle, Anna Munro, Mimi Tran, Mai Russell, Joe Vitale

**Board Counsel**
Charley Harris

**BOCC Liaison/Representatives**
Kenneth Jones

**Guests**
Teri Morrow, Nathan Dundes, Kristyn Brendle

The items are listed in the order of discussion.
►Indicates requesting for full Board approval

**Public Comments**
There was none.

**Approval of Minutes**

**October 18, 2018 Executive Committee Meeting**
A motion to approve the minutes of October 18, 2018 Executive Committee Meeting was made by Randall King and seconded by Roy Sweatman. The motion passed unanimously.

**October 18, 2018 CEO Search Committee Meeting**
A motion to approve the minutes of October 18, 2018 CEO Search Committee Meeting was made by Roy Sweatman and seconded by Jeff Serpico. The motion passed unanimously.

**► Section 125 Cafeteria Plan Benefits Stipend & Compensation Study**
*Refer to Page 7 of the December 13, 2018 Executive Committee Agenda Packet*

Board Treasurer West presented this item for consideration. She reported the Finance Committee approved the motion with a caveat that a compensation audit/study is conducted. The following points of discussion ensued:

- The 28% stipend applies to all [eligible] employees and is needed to be compliant with the Affordable Care Act.

- HR Consultant Teri Morrow clarified that the 28% stipend is the employer contribution to be used towards healthcare and related benefits. Only those employees with valid legal waivers can opt out of medical coverage. For example, providing evidence the employee is covered through their spouse's health care. Unused stipend is considered as wages and is taxable.
- Committee members expressed their concern with employees who opt out of medical coverage and receiving unused stipend as wages.
- For lowest wage earner, the stipend would cover between 40 – 60% of their deductibles.
- In an effort to not disrupt employee benefits and open enrollment for 2019, there was a consensus to approve the plan as is, with a caveat that a compensation study be conducted.

**A motion to approve the cafeteria plan & the benefit stipend at 28%, as presented, with a caveat that a compensation audit/study is to be conducted prior to open enrollment for 2020** was made by Randall King and seconded by Commissioner Sandra Murman. The motion passed unanimously.
**A motion to proceed with a Request for Proposal process for a compensation audit & study, including forming an ad hoc compensation committee** was made by Randall King and seconded by Commissioner Sandra Murman. The motion passed unanimously.

**Adjournment**
The meeting was adjourned at approximately 11:30 a.m.

# Staff Training

**Wagner Peyser, ReEmployment Services and Eligibility Assessments (RESEA) and Veterans Program – January 28th through 31st (Onsite)**

- Job Orders
- Case Noting in Employ Florida
- Employability Development Plans
- Placements and Obtained Employment
- Service Code Review
- Employer Services
- Jobseeker Registration
- Veterans Program

**Workforce Innovation and Opportunity Act (WIOA) - February 26th through March 1st (Onsite)**

- General WIOA Eligibility (Youth, Adults and Dislocated Workers)
- Measurable Skills Gain
- Eligible Training Provider List
- Work-Based Training
- Credentials/Credential Attainment
- Targeted Occupations List
- Service Code Review

The DEO team will also provide training on the Trade Program and Migrant Seasonal Farmworker Program during these visits. DEO will also prepare and provide a detailed agenda outlining the schedule for each day of training. CareerSource Pinellas has also requested programmatic training for their staff, so we would like to invite them to participate in these training sessions as well.

In addition to the above proposed training dates, DEO is also scheduled to conduct Welfare Transition training March 25-29, 2019 in Tampa and Supplemental Nutrition Assistance Program training February 19-21, 2019 in Orlando. These are statewide training sessions available to all local workforce boards.

# Upcoming DEO Audit Schedule

Fiscal Audit Review to be held on March 18 thru March 22, 2019.

Programmatic Monitoring Review to be held on April 8 thru 12, 2019.

# Action Item

# Related Party Contracts

## Background

Local Workforce Development Boards (LWDBs) are required to comply with all requirements of Section 445.007 prior to contracting with a board member, with an organization represented by its own board member, or with any entity where a board member has any relationship with the contracting vendor. This section mandates all RWBs, entering into a contract with an organization or individual represented on the Board, must meet the following requirements:

a) Approve the contract by a two-thirds (2/3rd ) vote of the Board, when a quorum has been established;
b) Board members who could benefit financially from the transaction or who have any relationship with the contracting vendor must disclose any such conflicts prior to the board vote on the contract;
c) Board members who could benefit financially from the transaction or board members who have any relationship with the contracting vendor must abstain from voting on the contracts; and
d) Such contracts must be submitted to the FL Dept. of Economic Opportunity and CareerSource Florida for review.

## Information

CareerSource Tampa Bay offers a number of programs to assist in training and maintaining a highly skilled workforce. These programs include:

- **On the Job Training program**, or OJT, assists companies find, interview and hire the right person for their job vacancies. The OJT program then provides a unique opportunity for employers to train their new employee to their standards and processes -skills learned are directly relevant to the work the employee will perform. Employers who hire new full time workers under OJT receive reimbursement of 50% of the candidate's hourly wages or salary for up to 10-weeks of employment if the individual meets certain eligibility criteria.

- **Paid Work Experience** is a CareerSource Tampa Bay program that works with local employers to place individuals who are just entering the world of work or others who are re-entering the job market into a position at their company. After placing them at the company, CareerSource Tampa Bay employs and pays them for 30 days. CareerSource Tampa Bay also covers all unemployment taxes and workers comp during this "trial" period.

- **Employed Worker Training** (EWT) program is designed to increase the current skills of employers' existing staff with training grants (each year for each company that submits a successful application).

  EWT is a great way for employers to invest in the professional development of their employees and provide them the opportunity to acquire industry recognized certifications that can be instrumental in moving the business forward. The employer chooses the training program and instructor and CareerSource Tampa Bay helps with the cost of training. This program is designed to promote business retention, while contributing to the overall economic growth within the area.

| **Action Item** | **Company** | **Board Director** | **EWT** (amt. not to exceed) | **OJT/PWE** (amt. not to exceed) |
|---|---|---|---|---|
| A | Tampa Tank | Mike Smith | $15K | $15K |
| B | Tampa General Hospital | Jeff Serpico | $50K | $50K |
| C | McKibbon Hospitality | Randall Hassan | $50K | $50K |
| D | GTE Financial | Jasiel Legon | | $50K |

## Recommendation

Approval of the related party contracts, by a two-third vote, when a quorum has been established.

# Action Item

# Agreement with Hillsborough Community College (HCC) to Provide Training for CareerReady Programs

**Information**

CareerSource Tampa Bay has available funding under the CareerSource Florida Sector Strategies Career Ready grant and local Workforce Innovation and Opportunity Act (WIOA) to provide short-term pre-vocational training in Welding, Soldering and Cabling, and Mechatronics/Robotics. CareerSource Tampa Bay has identified HCC as the training provider. HCC is currently an approved training provider with the capability to provide vocational training in Welding, Soldering and Cabling, and Mechatronics/Robotics. The estimated cost of the program is $563,000, serving approximately 185 participants through June 30, 2020.

**Recommendation**

Approve entering into contract negotiations with Hillsborough Community college to provide short-term pre-vocational training in Welding, Soldering and Cabling, and Mechatronics/Robotics at CareerSource Tampa Bay Career Prep Center located at 2605 N. 43rd Street, Tampa FL 33605 or at a mutually agreed upon HCC facility.

# Action Item
# Request For Qualifications (RFQ) Issuance: 2019 Business Associations

## Information

Each year CareerSource Tampa Bay issues an RFQ for Business Associations. Instead of membership dues being paid up-front, all fees/membership dues will be paid once the association has completed the contractually agreed-upon activities equal to the value dues set for the participating association. These activities are focused on promoting workforce programs and services to the association's members. This provides a foundation for establishing a working relationship with local Chambers of Commerce and various industry-specific business associations. The RFQ submissions will include a plan that outlines the expectations related to the ongoing promotion of CareerSource Tampa Bay's programs and services to local employers.

## Recommendation

Approve the issuance of the RFQ for Business Associations.

# Action Item
# Form 550 Wrap Documents

**Wrap Plan Document**
A 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 annual 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.

The Wrap Plan document was previously approved by the Board on September 20th subject to a final review by the corporate attorney. The document has now been reviewed and approved by the corporate attorney.

Staff is seeking Board approval to adopt the final Wrap Plan Document.

Attachments:

- Wrap Plan Document FAQs – Page 15
- Wrap Plan Document – Pages 16 - 55

## Recommendation
Approval of the final Wrap Plan Document.

## WHAT IS A WRAP DOCUMENT AND WHY DO I NEED ONE?

**What is a "wrap document"?**

A wrap document is a document that sets out information about an employer's health and welfare plan, and which incorporates (or "wraps around") other documents that provide more detailed information about the benefits offered (such as insurance policies, evidence of coverage, etc.). A wrap document can be used for:

- Multiple benefit coverages or a single benefit coverage
- Fully-insured and/or self-insured benefits
- Plan documents and/or summary plan documents

**If the other documents (e.g., insurance policies) provide detailed information about the benefits, what information does a wrap document have?**

- Specific eligibility provisions and exclusions
- General description of all benefits offered under a single plan
- Description of how different benefits interact with other benefits
- Employer's reservation of right to amend or terminate the plan
- Governance provisions such as specifying who has the power to interpret plan provisions, decide eligibility claims, etc.
- ERISA-required information that may be missing from insurer-prepared documents
- Other information affecting the plan as a whole and that is specific to the employer, such as benefit coverage during a leave of absence

**Why does an employer need a wrap document?**

- ERISA requires that all plans subject to ERISA have a governing plan document and a summary plan description. Insurance documents generally do not meet all of the specific requirements of ERISA for plan documents and summary plan descriptions.
- A wrap document is an important part of establishing a single ERISA plan, allowing an employer to file a single Form 5500 for multiple benefit coverages.
- Insurance-prepared documents are written from the insurers' perspective and generally do not contain language which is important or desirable to include from the employers' perspective.

**What are the potential consequences of <u>not</u> having a wrap document?**

- ERISA provides for penalties of up to $110 per day that may be assessed where an employer fails to provide plan documents to an employee who has requested such documents in writing within 30 days of the request.
- Without a wrap document to establish a single ERISA plan, an employer could be determined to have multiple, separate ERISA plans, each with its own Form 5500 filing requirement and applicable late penalties.
- Inaccurate or incomplete plan documents can increase the risk of participant claims and lawsuits – having a well written wrap document can help to mitigate these risks.

# CareerSource Tampa Bay
# Employee Health & Welfare Plan

WRAP PLAN

*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 **December 1, 2018**

Medcom
BENEFIT SOLUTIONS







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

TABLE OF CONTENTS

## 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.







**"Placed for Adoption"** 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.

**"Plan"** means the benefit programs that are described in this document, including all amendments thereto.

**"Plan Administration Functions"** 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.

**"Plan Year"** means each 12-consecutive month period ending on: **December 31**.

**"Seasonal Employee"** 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.

**"Spouse"** 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. This definition includes same sex spouses who are legally married. This definition does not include domestic partners.

**"Standard Administrative Period"** 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.

**"Standard Measurement Period"** 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.

**"Standard Stability Period"** 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.

**"Subsidiary Contract"** 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: **December 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, unpaid volunteer, or union employee (unless a collective bargaining agreement specifically provides for participation), 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. Applicable Measurement, Administrative, and Stability Periods

1. The Initial Measurement Period starts on the employee's date of hire and lasts 12 consecutive months.

2. The Initial Administrative Period, or its second part, lasts 1 month.

3. The Initial Stability Period begins the next day after the end of the Initial Administrative Period and lasts 12 consecutive months.

4. The Standard Measurement Period lasts 12 consecutive months. The Standard Measurement Period starts on November 1 and ends on October 31.

5. The Standard Administrative Period lasts 2 months. The Standard Administrative Period starts on November 1 and ends on December 31.

6. The Standard Stability Period lasts 12 consecutive months. The Standard Stability Period starts on January 1 and ends on December 31.

iii. 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) Eligibility for Dental, Vision, Group Life, Accidental Death & Dismemberment, Short-Term Disability, Long-Term Disability, Specified Voluntary Worksite, and Health Flexible Spending Account (FSA) Benefits

(i) The following provisions apply only with respect to eligibility for dental, vision, group life, accidental death & dismemberment, short-term disability, long-term disability, specified voluntary worksite, and health flexible spending account (FSA) 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, unpaid volunteer, or union employee (unless a collective bargaining agreement specifically provides for participation), 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.

(c) 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.

## 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:

| WELFARE BENEFIT | CARRIER OR TPA INFORMATION | FUNDING TYPE |
|---|---|---|
| Medical | Cigna HealthCare<br>900 Cottage Grove Road<br>Bloomfield, Connecticut 06002 | Fully-insured |
| Dental | Cigna HealthCare<br>900 Cottage Grove Road<br>Bloomfield, Connecticut 06002 | Fully-insured |
| Vision | Cigna HealthCare<br>900 Cottage Grove Road<br>Bloomfield, Connecticut 06002 | Fully-insured |
| Group Life | Cigna HealthCare<br>900 Cottage Grove Road<br>Bloomfield, Connecticut 06002 | Fully-insured |
| Accidental Death & Dismemberment | Cigna HealthCare<br>900 Cottage Grove Road<br>Bloomfield, Connecticut 06002 | Fully-insured |
| Short-Term Disability | Cigna HealthCare<br>900 Cottage Grove Road<br>Bloomfield, Connecticut 06002 | Fully-insured |
| Long-Term Disability | Cigna HealthCare<br>900 Cottage Grove Road<br>Bloomfield, Connecticut 06002 | Fully-insured |
| Specified Voluntary Worksite Plans | Colonial Life & Accident Insurance Company<br>P.O. Box 1365<br>Columbia, South Carolina 29202 | Fully-insured |
| Health Flexible Spending Account (FSA) | Ameriflex | Self-insured |





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

_____

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

Signature: _____

Print Name: _____

Title/Position: _____

# CareerSource Tampa Bay
# Employee Health & Welfare Plan

WRAP

**SUMMARY PLAN DESCRIPTION**

ERISA PLAN NUMBER 501

December 1, 2018

Prepared by

Medcom







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 December 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, unpaid volunteer, or union employee (unless a collective bargaining agreement specially provides for participation), 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.

The following Measurement, Administrative, and Stability Periods will apply:

The Initial Measurement Period starts on the employee's date of hire and lasts 12 consecutive months.

The Initial Administrative Period lasts 1 month.

The Initial Stability Period begins the next day after the end of the Initial Administrative Period and lasts 12 consecutive months.

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.

The Standard Administrative Period lasts 2 months. The Standard Administrative Period starts on November 1 and ends on December 31.

The Standard Measurement Period lasts 12 consecutive months. The Standard Measurement Period starts on November 1 and ends on October 31.

The Standard Stability Period lasts 12 consecutive months. The Standard Stability Period starts on January 1 and ends on December 31.

**Ongoing Employee Measurement/Stability Period**

| *Type* | *Length* | *Start Date* | *End Date* |
|---|---|---|---|
| Standard Measurement Period | 12 months | November 1 | October 31 |
| Standard Administrative Period | 2 months | November 1 | December 31 |
| Standard Stability Period | 12 months | January 1 | December 31 |

*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 Dental, Vision, Group Life, Accidental Death & Dismemberment, Short-Term Disability, Long-Term Disability, Specified Voluntary Worksite, and Health Flexible Spending Account (FSA) 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, unpaid volunteer, or union employee (unless a collective bargaining agreement specially provides for participation), 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.

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.

Compliance with Federal Welfare Benefit Plan Requirements

To the extent required by law, the Plan shall comply with the following benefit and coverage laws and provisions:

1. ERISA
2. COBRA
3. HIPAA
4. Women's Health & Cancer Rights Act (WHCRA)
5. FMLA
6. Uniformed Services Employment and Reemployment Rights Act (USERRA)
7. Heroes Earning Assistance and Relief Tax Act (HEART Act)
8. Medicaid
9. Medicare
10. Children's Health Insurance Program (CHIP)
11. Pediatric Vaccines
12. The Americans with Disability Amendments Act (ADA)
13. Medical Child Support Order
14. Michelle's Law
15. Newborns' and Mothers' Health Protection Act
16. Mental Health Parity and Addiction Equity Act (MHPAEA)
17. Genetic Information Nondiscrimination Act (GINA)
18. Patient Protection and Affordable Care Act (PPACA)
19. National Defense Authorization Act (NDAA)

## NOTICE OF PRIVACY PRACTICES

*This notice describes how medicol 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/.
- 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 hove 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 exomple if you are unconscious, we may go ahead ond share your information if we believe it is in your best interest. We may also share your informotion when needed to lessen o serious and imminent threot 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 diognosis 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 yau 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 poyment for your dental work.*

**Administer your plan**

- We may disclose your health information to your health plan sponsor for plan administration.
- *Example: Your company controcts with us to provide o 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.

**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.

**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.

**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. (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.

**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:

| WELFARE BENEFIT | CARRIER OR TPA INFORMATION | FUNDING TYPE |
|---|---|---|
| Medical | Cigna HealthCare<br>900 Cottage Grove Road<br>Bloomfield, Connecticut 06002 | Fully-insured |
| Dental | Cigna HealthCare<br>900 Cottage Grove Road<br>Bloomfield, Connecticut 06002 | Fully-insured |
| Vision | Cigna HealthCare<br>900 Cottage Grove Road<br>Bloomfield, Connecticut 06002 | Fully-insured |
| Group Life | Cigna HealthCare<br>900 Cottage Grove Road<br>Bloomfield, Connecticut 06002 | Fully-insured |
| Accidental Death & Dismemberment | Cigna HealthCare<br>900 Cottage Grove Road<br>Bloomfield, Connecticut 06002 | Fully-insured |
| Short-Term Disability | Cigna HealthCare<br>900 Cottage Grove Road<br>Bloomfield, Connecticut 06002 | Fully-insured |
| Long-Term Disability | Cigna HealthCare<br>900 Cottage Grove Road<br>Bloomfield, Connecticut 06002 | Fully-insured |
| Specified Voluntary Worksite Plans | Colonial Life & Accident<br>Insurance Company<br>P.O. Box 1365<br>Columbia, South Carolina 29202 | Fully-insured |
| Health Flexible Spending Account (FSA) | Ameriflex | Self-insured |





## GLOSSARY

**"Affiliated Employer"** means a related company which adopts the Plan and participates in one or more of the benefits offered under the Plan.

**"COBRA"** 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.

**"Dependent"** means any person who qualifies as a dependent under a subsidiary contract for purposes of that contract.

**"Eligible Employee"** Is an employee who meets the eligibility requirements for one or more of the benefits offered under this Plan.

**"Employer"** means the company sponsoring the Plan and any related companies which participate in one or more of the benefits offered under the Plan.

**"ERISA"** means the Employee Retirement Income Security Act of 1974.

**"FMLA"** means the Family Medical Leave Act of 1993.

**"HIPAA"** means the Health Insurance Portability and Accountability Act of 1996.

**"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 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.

**"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.

**"Ongoing Employee"** means an employee who was employed with the Employer on the first day of a Standard Measurement Period.

**"Participant"** means an employee who participates in benefits that are offered under this Plan.

**"PHI"** means Protected Health Information as defined under HIPAA.

**"Plan"** means the benefit programs that are described in this document.

**"Plan Year"** means each 12-consecutive month period ending on: **December 31**.

**"Seasonal Employee"** 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.

**"Spouse"** means an individual who is lawfully married under any state law or as currently recognized under prevailing Federal law. This definition includes same sex spouses who are legally married. This definition does not include domestic partners.

**"Standard Administrative Period"** 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.

**"Standard Measurement Period"** 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.

**"Standard Stability Period"** 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.

**"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.

**"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 or program that is offered by the Employer in order to provide ERISA-listed benefits to Eligible Employees, other than pension or retirement programs.

# Presentation on One Stop Partners Web Portal
# By Dan McGrew, Dynamic Workforce Solutions

## Information

CareerSource Tampa Bay's One Stop Operator, Dynamic Workforce Solutions, along with staff and IT provider, CTS have been working diligently to design and implement an Online Partner Portal. The purpose of this Online Partner Portal is to maintain effective linkages between CSTB, mandatory WIOA partners and community partners that support its core vision and mission. The Online Partner Portal will improve communication, referral, service delivery, and tracking of performance of the partners.

Part of this process required us to identify and understand all of the mandatory and co-locate partners, gather information and a description of services provided that support the one-stop system. Next we discussed and determined the best approach to receiving referrals. Then we collected detailed contact information, descriptive programmatic information at each organization. The goal is for the Online Partner Portal to allow the partners to easily post and access forms, processes, performance tracking, etc. in a centralized format.

The draft Online Partner Portal has been presented at the quarterly One Stop Career Center Partner Meetings to gauge feedback. This concept has also been introduced and discussed with the One Stop Committee. The Online Partner Portal will be made available to both the Career Source Tampa Bay staff and Partner Staff. We are truly excited about the implementation of the Online Partner Portal, as this is a unique design as no other Florida local workforce development board has created such a robust portal that will allow us to execute service provision and track performance.

As CSTB staff interact with customers who have a need, our team will be able to immediately address their challenge through the portal by identifying available resources and executing referrals. Direct linkages will be provided to the customer through prescriptive service provision. The partner program, customer and CSTB will all receive an email confirmation of the referral transaction.