# 2023 State of Florida Salary Reduction Cafeteria Plan

**with Premium Payment, Health Savings Account, and Flexible Spending Accounts**

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## ARTICLE I – INTRODUCTION

### 1.1 Establishment of Plan

A Cafeteria Plan is an employer-sponsored plan that lets employees deduct dollars from their paychecks before they are taxed and use the money to pay for certain insurance premiums, as well as pay into Flexible Spending Accounts or Health Savings Accounts. The Department of Management Services, Division of State Group Insurance, established the State of Florida Flexible Benefits Plan effective July 1, 1989. The Department of Management Services, Division of State Group Insurance, hereby amends, restates, and continues the State of Florida Flexible Benefits Plan, hereinafter known as the State of Florida Salary Reduction Cafeteria Plan ("the Plan"), effective January 1, 2023.

This Plan is designed to permit an Employee to pay by a Salary Reduction Agreement on a Pretax basis for his or her share of eligible contributions or premiums under the Health Insurance Plan, Prescription Drug, Dental, Vision, group Life Insurance, and Supplemental Insurance Plans. The Plan also permits an Employee to contribute to a Health Savings Account (HSA) or Flexible Spending Account (FSA) for Pretax reimbursement of certain Medical Care Expenses and Dependent Care Expenses, as applicable.

### 1.2 Legal Status

This Plan is intended to qualify as a "Cafeteria Plan" under Section 125 of the Internal Revenue Code 1986, as amended (the "Code"), and regulations issued thereunder. This Plan is supplemented by the applicable provisions of Part I of Chapter 110, Florida Statutes (F.S.), and rules set forth in Chapter 60P, Florida Administrative Code (F.A.C.), as amended from time to time.

The Medical Reimbursement Component is intended to qualify as a self-insured Medical Reimbursement Plan under Code Section 105, and the Medical Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code Section 105(b).

The Dependent Care FSA Component is intended to qualify as a Dependent Care assistance program under Code Section 129, and the Dependent Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code Section 129(a).

The Medical Reimbursement Component and the Dependent Care FSA Component are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code Sections 105 and 129. The Medical Reimbursement Component is also a separate plan for purposes of applicable provisions of Health Insurance Portability and Accountability Act (HIPAA) and the Consolidated Omnibus Budget Reconciliation Act (COBRA).

The Life Insurance Plan Component of the Plan is intended to meet the requirements of Code Section 79.

### 1.3 Hierarchy of Legal Authority

Should dispute or legal issues arise regarding this Plan, the Cafeteria Plan shall control to the extent it is consistent with the IRS Code Section 125 and applicable final and proposed federal regulations, followed by section 123.161(6), Florida Statutes, other state statutes and then Rule 60-P, Florida Administrative Code.

## ARTICLE II – DEFINITIONS AND CONSTRUCTION

### 2.1. Definitions

Terms used but not otherwise defined in this Plan shall have the same meaning as defined in Rule 60P-1.003, F.A.C.

(1) "Administrator" for purposes of this document is the Department of Management Services, Division of State Group Insurance (the contact person is the Director, Division of State Group Insurance). The Administrator may, however, delegate any of its powers or duties under the Plan in writing to any person.

(2) "Carryover" means the automatic carry forward of all or a portion of unused Healthcare FSA and Limited Purpose FSA funds from one Plan Year to the next Plan Year as described in Article VI of this Plan.

(3) "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

(4) "Compensation" means the total Form W-2 compensation for federal income tax withholding purposes paid by the Employer to an Employee for services performed, determined prior to any Salary Reduction election under this Plan, prior to any salary reduction election under any other Code Sections 132, 401(k), 403(b), or 408(k) arrangement.

(5) "Dependent" for purposes of insurance coverage means Eligible Dependents as set forth in Rule 60P-1.003(8), FAC.

(6) "Dependent" for the purpose of the Medical Reimbursement Component includes any individual who is a dependent of a Participant as defined in Code Section 152. Notwithstanding the foregoing, the Health Insurance Plan and Medical Reimbursement Component of this Plan will provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order (QMCSO) even if the child does not meet the definition of Dependent.

(7) "Dependent Care Component" means the component of the Plan providing the Dependent Care Expense benefits described in Article VII of the Plan.

(8) "Dependent Care Expenses" means expenses considered to be Employment-Related Expenses under Code 21 (b)(2) (relating to expenses for household and Dependent care services necessary for gainful employment of the Participant and Spouse, if any), if paid for by the Participant to provide Qualifying Dependent Care Services as defined by the Internal Revenue Publication 503.

(9) "Dependent Care Flexible Spending Account" or "Dependent Care FSA" means the account described in Article VII of this Plan.

(10) "Eligible former employee" means a former state officer or employee who was enrolled in the state group insurance program for at least 6 cumulative years with an employer or employers participating in the state group insurance program, and who was enrolled in the state group insurance program at the time of his or her separation from employment and whose separation from employment occurred on or after July 1, 2022, as defined in Section 110.123(2)(b), F.S., as amended from time to time.

(11) "Employee" means a full-time state employee as defined in Section 110.123(2)(c), F.S., and, unless otherwise noted, a part-time employee as defined in Section 110.123(2)(f), F.S.

(12) "Employment-Related Expenses" means those Dependent Care Expenses paid or incurred incident to maintaining employment after the date of the Employee's participation in the Dependent Care Component of this Plan, other than amounts paid to:

- An individual with respect to whom a Dependent deduction is allowable under Code 151(a) to the Participant or the Participant's Spouse;
- The Participant's Spouse; or
- A child of the Participant who is under 19 years of age.

(13) "Employer" means an entity that participates in the State Group Insurance Program and employs a Participant.

(14) "Flexible Spending Account" or "FSA" means the Healthcare FSA, Limited Purpose FSA, or Dependent Care FSA.

(15) "Grace Period" means January 1 through March 15 of the calendar year following the Plan Year, or the date extended by federal order, and only applies to the Dependent Care FSA.

(16) "Healthcare Flexible Spending Account" or "Healthcare FSA" means the account described in Article VI of this Plan.

(17) "Health Insurance Plan" means the plan(s) that the Sponsor maintains for Employees (and for their eligible Dependents), providing medical benefits either through a self-funded plan or through a group insurance policy or policies (including HMOs and group Supplement offerings) and qualify as accident or health plans under Code 106 (other than a long-term care insurance plan). It also includes the prescription drug, dental and vision benefits and employee assistance program, all of which are underlying benefits. Subject to approval by the Florida Legislature, the Sponsor and/or Administrator may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits, terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan. The specific coverage selected by the Participant (for the Participant, Spouse and/or eligible Dependents) is considered the Participant's Health Insurance Plan coverage for purposes of this Plan. Health Insurance Plan includes any "Health Program" where Employees are allowed to make pre-tax contributions.

(18) "Health Savings Account" or "HSA" means a tax-favored trust or custodial account that the Participant establishes with the qualified HSA Trustee to pay or be reimbursed for eligible medical expenses. HSA means the account described in Article VIII of this Plan.

(19) "High Deductible Health Plan" means the high-deductible health plan offered by the Sponsor as a benefit option under the Health Insurance Plan that is intended to qualify as a high-deductible health plan under Code Section 223(c)(2), as described in materials provided separately by the Sponsor.

(20) “Life Insurance Plan” means the plan(s) that the Sponsor maintains for Participants providing life insurance benefits through a group insurance policy or policies, which plan or plans qualify as group term life insurance plans under Code 79. The Sponsor and/or Administrator may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits, terms and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

(21) “Limited Purpose Flexible Spending Account” or “Limited Purpose FSA” means an arrangement under which a Participant may set aside money on a Pretax basis via Salary Reduction to pay for eligible dental and vision expenses.

(22) “Medical Care Expense” means an expense incurred by a Participant, spouse or Dependent of such Participant, for medical care as defined in Code 213 (including, for example, amounts for certain hospital bills, doctor bills and prescription and over-the-counter drugs), other than expenses that are excluded but only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through the Health Insurance Plan, other insurance or any other accident or health plan.

(23) “Medical Reimbursement Component” means the component of the Plan providing the medical reimbursement benefits described in Article VI of the Plan.

(24) “Open Enrollment Period” with respect to a Plan Year means the period, as designated by the Administrator, preceding a Plan Year in which Employees may make salary reduction elections for such Plan Year.

(25) “Participant” means an Employee who has elected to participate in the Plan in accordance with Articles III and IV.

(26) “Plan” means the State of Florida Salary Reduction Cafeteria Plan as set forth herein and as amended from time to time.

(27) “Plan Year” means the calendar year commencing on January 1 and ending on December 31.

(28) “Premium Payment Component” means the component providing the premium payment benefits described in Article V of this Plan.

(29) “Pretax” means an arrangement whereby insurance premiums are deducted from the Participant’s pay before taxes are calculated.

(30) "Qualifying Status Change Event" and "QSC Event(s)" – as defined in the Qualifying Status Change (QSC) means an occurrence that affects eligibility for coverage qualifies an Employee to make an insurance coverage or FSA change outside of Open Enrollment.

(31) “Run-Out Period” means the time that Participants may file a claim for the prior Plan Year, for an FSA Plan in accordance with Article VI and VII respectively, of this Plan.

(32) “Salary Reduction Agreement” means an agreement by which a Participant specifies an election of the benefits described in Section 4.1 of this Plan for which he is eligible and, to the extent required, elects to reduce Compensation in order to purchase such benefits under the Plan.

(33) "Shared Savings Program" means the price transparency and bundled surgical services plans implemented under sections 110.1245 and 110.12303, Florida Statutes.

(34) "Sponsor" means the State of Florida, Department of Management Services, Division of State Group Insurance, through action authorized by the Legislature pursuant to section 110.123, Florida Statutes.

(35) "Supplemental Insurance Plan" means the plan(s) that the Sponsor maintains for Employees providing benefits through a group insurance policy or policies, which plan, or plans qualify as accident or health plans under Code 106 (other than a long-term care insurance plan). Upon approval by the Florida Legislature, the Sponsor and/or Administrator may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits, terms and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this plan. The specific coverage selected by the Employee is considered the Supplemental Insurance Plan coverage for purposes of the Plan.

## ARTICLE III – ELIGIBILITY AND PARTICIPATION

### 3.1 Eligibility

Any Employee who was a Participant in the Plan on the effective date of this amendment and restatement shall be eligible to continue participation in the Plan. Every other Employee shall become eligible to participate in the Plan upon employment with the Employer or a QSC Event. The Administrator or its agent shall provide each Employee with a written notice of their eligibility in the Plan and instructions on how to submit a Salary Reduction Agreement. Other Personal Services (OPS) Employees who have worked an average of at least 30 or more hours per week during the measurement period described in s. 110.123(14)(c) or (d), or who are reasonably expected to work an average of at least 30 or more hours per week following his or her employment, are eligible to participate in the state group insurance program, pursuant to section 110.131, Florida Statutes.

### 3.2 Participation

To become a Participant, an Employee shall agree to reduce his or her salary ("Salary Reduction Agreement") within sixty (60) calendar days of initial employment with the Employer, or the date as extended by federal or state order. By entering into a Salary Reduction Agreement, the Employee shall be deemed for all purposes to have agreed to participate and conform to the requirements of the Plan. Participation shall commence as of the first day of the month following, or first day of the second month following, the date on which the Participant files a Salary Reduction Agreement with the Administrator or its agent, except that participation in the Medical Reimbursement Component of this Plan shall commence upon receipt of the Salary Reduction Agreement by the Administrator or its agent.

Except as otherwise provided in Sections 5.6, 6.4, and 7.4 of this Plan, if an Employee fails to agree to the Salary Reduction Agreement or to otherwise comply with the participation requirements of this Plan within sixty (60) calendar days of initial employment with the Employer, such Employee shall not become a Participant, but may become a Participant by subsequently executing and filing a Salary Reduction Agreement with the Administrator or its agent during a QSC Event or the Open Enrollment Period for succeeding Plan Years.

For Plan Years 2020 (beginning with the Federal Public Health Emergency) through the end of the Federal Public Health Emergency, QSC Event deadlines were extended until 120 days after the end of the Federal Public Health Emergency for QSC Events that occurred during the stated period, unless stated otherwise in other articles of this document. A QSC Event is not required to make a change to an HSA.

### 3.3 Termination of Participation

Except for Eligible Former Employees, a Participant will cease to be a Participant in the Plan (or in any component thereof) upon the earlier of:

- The termination of this Plan;
- The date on which the Participant becomes ineligible for benefits under the terms of each of the plans described in Section 4.1. of this Plan;
- The date on which the Participant ceases (because of retirement, death, termination of employment, layoff, reduction in hours, or any other reason) to be a Participant eligible to participate under Article III; or
- The date the Participant revokes his election to participate under a circumstance when such change is permitted under the terms of this Plan.

Reimbursements after termination of participation will be made pursuant to Sections 6.6 and 7.6.

### 3.4 Family and Medical Leave Act of 1993

Notwithstanding any provision to the contrary in the Plan, if a Participant goes on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA), then to the extent required by the FMLA, the Employer will continue to maintain the Participant's Health Insurance Plan benefits on the same terms and conditions as if the Participant were still actively at work. That is, if the Participant elects to continue his coverage while on leave, the Employer will continue to pay its share of the premium. A Participant may elect to continue his coverage under the Premium Payment and/or Medical Reimbursement Component of the Plan during the FMLA leave. If the Participant elects to continue coverage while on leave, the Participant may pay the Participant's share of the premium in one of the following ways:

- With after-tax dollars, by sending monthly payments to the Administrator or its agent;
- With Pretax dollars, by pre-paying all or a portion of the premium for the expected duration of the leave on a Pretax salary reduction basis out of pre-leave Compensation. To pre-pay the premium, the Participant must make a special election to the effect prior to the date that such Compensation would normally be made available (note, however, that Pretax dollars may not be used to fund coverage during the next Plan Year); or,
- Under another arrangement agreed upon between the Participant and the Administrator.

If a Participant's coverage ceases while on FMLA leave, the Participant will be permitted to reenter the Plan upon return from such leave on the same basis the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA.

## ARTICLE IV – BENEFIT ELECTIONS

### 4.1 Benefit Options

A Participant may choose under the Plan to receive his full Compensation for any Plan Year in cash or to designate a portion of his Compensation for each Plan Year to be applied by the Administrator or its agent towards the cost of one or more of the following benefits:

a) Benefits available under a Health Insurance Plan as described in Article V of this Plan;
b) Benefits available under a Life Insurance Plan as described in Article V of this Plan;
c) Benefits available under a Supplemental Insurance Plan as described in Article V of this Plan;
d) Benefits available under a Medical Reimbursement Component (FSA) as described in Article VI of this Plan;
e) Benefits available under a Dependent Care Component as described in Article VII of this Plan;

f) Benefits available under an HSA as described in Article VIII of this Plan; and
g) Such other benefits as may be made available by the Administrator by amendment hereto.

### 4.2 Election of Benefits in Lieu of Cash

If a Participant elects a benefit described in Section 4.1(d) and (e), the Participant's Compensation will be reduced by an amount equal to the reduction and will be paid or credited by the Employer to a reimbursement account in accordance with the Medical Reimbursement Component or the Dependent Care Component, as the case may be. If a Participant elects a benefit described in Section 4.1(a), (b), or (c), the Participant's Compensation will be reduced and an amount equal to the reduction will be utilized by the Sponsor under the terms of the Health Insurance Plan, Life Insurance Plan, or Supplemental Insurance Plan to cover the cost of benefits under such plans.

### 4.3 Salary Reduction Agreement

Each Participant's Salary Reduction Agreement shall remain in effect for the entire Plan Year to which it applies, shall be irrevocable (except as provided in Sections 5.6, 6.4, and 7.4), shall automatically carry forward to the next Plan Year if no changes are requested by the Participant, and shall set forth the amount of the Participant's Compensation to be used to purchase or provide benefits and the benefits to be purchased or provided. The Salary Reduction Agreement shall automatically be adjusted based on premium changes for the elected Plans.

## ARTICLE V – PREMIUM PAYMENT COMPONENT

### 5.1 Benefits

The benefits available to an Employee under this Premium Payment Component of the Plan are available to those Employees who pay for their share of the costs of the benefits on a Pretax basis through this Plan. An Employee can elect to participate in the Premium Payment Component of the Plan by electing to pay for his share of the premiums under the Health Insurance Plan, Life Insurance Plan, and Supplemental Insurance Plan with Pretax salary reduction dollars. An Employee may elect not to pay his share of the premiums under the Health Insurance Plan and/or Life Insurance Plan through the Premium Payment Component and instead pay for his share of the premiums with after-tax dollars outside of this Plan; however, he is still subject to the QSC Event requirements of this Plan. A Participant may only pay for his share of the premiums for any Supplemental Insurance Plan by electing to participate in the Premium Payment Component of the plan, and by paying his share of the premiums for such Supplemental Insurance Plan through this Plan.

### 5.2 Contributions

If an Employee elects to participate in the Premium Payment Component, the Participant's share of the premium for the plan benefits elected by the Participant will be financed by salary reductions. The salary reduction for each pay period for a Participant is an amount equal to the annual premium divided by the number of pay periods in the Plan Year, or an amount otherwise agreed upon. Salary reductions are applied by the Employer to pay for the premium for the Participant's benefits. The Employer will pay under this Plan, its share, if any, of the premiums for Participants who elect to participate in the Pretax feature of this Plan. For an Employee who does not elect the benefits with respect to the Health Insurance Plan or Life Insurance Plan under this Premium Payment Component Plan, and for those Employees to whom the benefits of this section, or any part thereof, are not available, both the Employee portion, if any, and the Employer portion of the premiums will be paid outside of this Plan. The Employer does not contribute any of the premium cost of any Supplemental Insurance Plan.

### 5.3 Health Benefits Provided Under the Health Insurance Plan

Health benefits will not be provided by this Plan, but by the Health Insurance Plan. The types and amounts of benefits available under the Health Insurance Plan, the requirements for participating in the Health Insurance Plan, and the other terms and conditions of coverage and benefits of the Health Insurance Plan are set forth in the Health Insurance Plan. All claims to receive benefits under the Health Insurance Plan shall be subject to and governed by the terms and conditions of the Health Insurance Plan and the rules, regulations, policies, and procedures adopted in accordance therewith.

### 5.4 Life Benefits Provided Under the Life Insurance Plan

Life benefits will be provided not by this Plan but by the Life Insurance Plan. The types and amounts of benefits available under the Life Insurance Plan, the requirements for participating in the Life Insurance Plan, and the other terms and conditions of coverage and benefits of the Life Insurance Plan, are set forth in the Life Insurance Plan. All claims to receive benefits under the Life Insurance Plan shall be subject to and governed by the terms and conditions of the Life Insurance Plan and the rules, regulations, policies, and procedures adopted in accordance therewith.

### 5.5 Supplemental Benefits Provided Under the Supplemental Insurance Plan

Supplemental benefits will be provided not by this plan but by the Supplemental Insurance Plan. The types and amounts of benefits available under the Supplemental Insurance Plan, the requirements for participating in the Supplemental Insurance Plan and the other terms and conditions of coverage and benefits of the Supplemental Insurance Plan are set forth in the Supplemental Insurance Plan. All claims to receive benefits under the Supplemental Insurance Plan shall be subject to and governed by the terms and conditions of the Supplemental Insurance Plan and the rules, regulations, policies, and procedures adopted in accordance therewith.

### 5.6 Irrevocability of Election

Except as described in the State of Florida QSC Event Matrix, a Participant's election under the Premium Payment Component of this Plan is irrevocable for the duration of the Plan Year to which it relates. In other words, unless one of the QSC Events occurs, a Participant may not change any elections for the duration of the Plan Year regarding participation in this Plan, salary reduction amounts, or the election of particular benefits, unless allowed or required by a federal order.

## ARTICLE VI – MEDICAL REIMBURSEMENT COMPONENT

### 6.1 Benefits

An election to participate in the Medical Reimbursement Component of this plan is an election to receive benefits in the form of reimbursements for Medical Care Expenses and to pay the premium for such benefits via Salary Reduction. A Participant may elect to participate in either a Healthcare FSA or a Limited Purpose FSA or none at all.

An Employee can elect to deposit Shared Savings rewards into a Healthcare FSA or a Limited Purpose FSA (depending on eligibility) and those rewards will post in January of the following calendar year.

### 6.2 Maximum and Minimum Benefits

The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Plan Year shall be the maximum amount allowed by the Internal Revenue Service for the Plan Year, plus any maximum permissible funds carried over from the previous Plan Year, as applicable. The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Plan Year shall be $60. The maximum amount that can be contributed to a flexible spending account

in any Plan Year is the maximum amount permitted by federal law. Amounts received that are attributable to reimbursements due for Medical Care Expenses incurred by the Participant's Spouse or Dependents shall be attributed to the Participant. For subsequent Plan Years, the elected annual benefit amount will remain in effect for the subsequent Plan Year unless the election amount is changed by the Participant during the Open Enrollment Period.

### 6.3 Benefit Premiums; Salary Reduction Contributions

The annual contribution for a Participant's benefits is equal to the annual benefit amount elected by the Participant (for example, if the maximum $2,750 annual benefit amount is elected, the annual contribution amount is also $2,750 as adjusted for inflation pursuant to Code Section 125(i)). The Salary Reduction for each pay period for a Participant is an amount equal to the annual contribution divided by the number of deductible (maximum deductible periods of twelve (12) for monthly pay cycle and twenty-four (24) biweekly pay cycle) pay periods remaining in the Plan Year, or an amount otherwise agreed upon. Salary Reductions are applied by the Employer to pay for the contribution for the Participant's benefits and, for the purposes of the Plan, they are considered Employer contributions.

### 6.4 Irrevocability of Election

Except as described in the State of Florida QSC Event Matrix, a Participant's election under the Premium Payment Component of this Plan is irrevocable for the duration of the Plan Year to which it relates. In other words, unless one of the QSC Events occurs, a Participant may not change any elections for the duration of the Plan Year regarding Participation in this Plan, Salary Reduction amounts, or the election of particular benefits, unless otherwise required by a federal order.

No Participant shall be allowed to reduce their election for Healthcare FSA or Limited Purpose FSA benefits to a point below the greater of the amount contributed and the amount reimbursed for the Plan Year. For example, if a Participant made a $2,400 annual election, for which they have contributed $1,200 toward and had been reimbursed for $2,000, the Participant would not be able to reduce their election below $2,000 (greater amount).

### 6.5 Carryover

The Carryover amount is equal to the maximum amount allowed under IRC Section 125(i) as amended. The amount of the Carryover will be published annually on the Plan's website prior to each Open Enrollment. Carryover funds are those Participant HealthCare FSA or Limited Purpose FSA funds held by the Plan that remain unused at the end of the Plan Year which are eligible to be carried over to the subsequent Plan Year.

Eligible funds shall automatically Carryover for eligible Participants from one Plan Year to the next Plan Year and be available for use for eligible expenses. If a Participant loses eligibility for participation in the Healthcare FSA due to moving into an HDHP and HSA from one Plan Year to the next Plan Year, the funds in the Healthcare FSA shall be carried forward to the next Plan Year and converted to a Limited Purposed FSA, making the funds available to pay for eligible dental and vision expenses.

Carryover amount shall be automatically reduced if claims are filed and reimbursed for the prior Plan Year during the Run-Out Period.

Beginning in Plan Year 2023, the Carryover limit for HealthCare and Limited Purpose FSA accounts increased to $610 which is 20 percent of the maximum contribution limit for HealthCare and Limited Purpose FSAs.

### 6.6 Reimbursement Procedure

Under the Medical Reimbursement Component, a Participant may receive reimbursement for Medical Care Expenses incurred during the Plan Year for which an election is in force. Reimbursement for Medical Care Expenses of the maximum dollar amount elected by the Participant for a Plan Year plus the Participant's eligible Carryover amount from the prior Plan Year (reduced by prior reimbursements for the applicable Plan Year) shall be available at all times during the Plan Year, regardless of the actual amounts credited to the Participant's Healthcare FSA or Limited Purpose FSA. Notwithstanding the foregoing, no reimbursements will be available for expenses incurred after coverage under this Plan has terminated, unless the Participant has elected COBRA as provided in Section 6.9 of this Plan, or unless provided otherwise in accordance with federal law.

A Participant who has elected to receive medical reimbursement benefits for a Plan Year may request reimbursement as prescribed by the Administrator or delegate during the Plan Year in which the expense was incurred or postmarked during the Run-Out Period following the close of the Plan Year. The request for reimbursement must include:

- The person or persons on whose behalf the expenses have been incurred;
- The nature of the expenses incurred;
- The amount of the requested reimbursement;
- The date the service was incurred; and
- A statement that such expenses have not otherwise been paid and are not expected to be paid through any other source.
- The request shall be accompanied by bills, invoices, or other statements from an independent third party showing the amounts of such expenses, together with any additional documentation which the Administrator or its agent may request.

As soon as practicable after the Participant submits a reimbursement claim to the Administrator or its agent, the Administrator or its agent will reimburse the Participant for the Participant's approved Medical Care Expenses, or the Administrator or its agent will notify the Participant that the claim has been denied.

If a claim is deemed incomplete or insufficient, the Participant must submit additional documentation to the Administrator or its agent, which must be postmarked no later than April 30th for the prior calendar year, or the date extended by federal order.

If a Participant does not submit enough qualified expenses to receive reimbursements for the full amount of coverage elected for a Plan Year by the end of the Run-Out Period for the Plan Year, then any amount in excess of the Carryover amount, as defined in Section 6.5, will be forfeited and applied by the Administrator in accordance with Section 10.1.

If improper reimbursement of ineligible FSA expenses has been made, the claim will be reprocessed, and the following corrective procedures will be used to recoup the amount reimbursed in error:

- Substitute any paper claims filed for reimbursement;
- Accept a personal check or money order;
- Initiate payroll deductions; or
- Pursue collection of the ineligible expense pursuant to Rule 69I-21.004, F.A.C.*(j) Expenses That May Be Reimbursed.*

Healthcare FSA or Limited Purpose FSA amounts may not be used to reimburse qualified Dependent Care Expenses.

### 6.7 Run-Out Period

For the Healthcare FSA and Limited Purpose FSA Plans, the Run-Out Period shall begin on January 1 of the year following the Plan Year. For Plan Years 2019-2021, the Run Out Period was extended one year beyond the normal run-out date which was the tax filing deadline for the respective plan year. For Plan Year 2022, the Run Out Period ends on October 23, 2023. For Plan Years beginning in 2023, the Run Out Period ends on April 30. The Run-Out Period end date shall automatically extend based on federal order extending the date for IRC Section 125 Cafeteria plans.

### 6.8 Payment Card

Healthcare FSA or Limited Purpose FSA Participants will be issued a payment card that can be used to pay merchants electronically at the point of sale for allowable expenses. Participants may be required to provide documentation substantiating the eligibility of the payment. If documentation is insufficient, these actions, with notice to the Participant, will be taken:

- First, suspend payment card privileges, which will be reinstated upon substantiation or recoupment and then the following actions will be taken in an order applicable to all Participants:
- Substitute any paper claims filed for reimbursement towards the ineligible or unsubstantiated card payments;
- Accept personal check or money order to clear the ineligible or unsubstantiated expenses;
- Initiate payroll deductions to clear the ineligible or unsubstantiated expenses;
- Pursue collection of the ineligible or unsubstantiated expenses pursuant to Rule 69I-21.004, F.A.C., *Recovery of Nonsalary Sums Due the State from State Officers and Employees*, which is adopted by reference, as amended from time to time.

When a Participant's employment is terminated, the payment card is turned off on the last day of the coverage month (same day as all other benefits). If the Plan is continued through a COBRA election as provided in Section 6.9 of this Plan or if Participant fully funds their FSA through the calendar year using unused annual or sick leave, the card is turned off on December 31st.

### 6.9 Reimbursements After Termination

When a Participant ceases to be a Participant under Section 3.3, the Participant's Salary Reductions will terminate, as will the Participant's election to receive reimbursements. The Participant will not be able to receive reimbursements for eligible expenses incurred after their participation terminates. However, such Participant (or the Participant's estate) may claim reimbursement for any eligible expenses incurred during the period of coverage prior to termination, provided that the Participant (or the Participant's estate) files a claim by the end of the Run-Out Period.

To the extent required by federal law (see, e.g., Code Section 4980B), a Participant, and the Participant's Spouse and Dependents, whose coverage terminates under the Medical Reimbursement Component of this Plan because of a COBRA qualifying event shall be given the opportunity to continue coverage under this Plan if at the time of separation, the Participant has not spent more than they contributed into the Plan, the balance of the annual election amount is received by the Administrator or its agent under one of the following methods:

- Deduction on a Pretax basis from any amounts due the Participant for unused leave balances;
- Payment of the full remaining amount of the election by personal check at the time of termination; or,
- Equal Post-tax monthly payments such that the balance of the annual election is paid over the remaining months of the Plan Year.

If COBRA is elected, it will be available only for the year in which the qualifying event occurs; such COBRA coverage for the Medical Reimbursement Component will cease at the end of the Plan Year and cannot be continued for the next Plan Year.

## ARTICLE VII – DEPENDENT CARE COMPONENT

### 7.1 Benefits

An election to participate in the Dependent Care Component of this plan is an election to receive benefits in the form of reimbursements for eligible Employment-Related Expenses, and to pay the premium for such benefits via Salary Reduction.

### 7.2 Maximum and Minimum Benefits

The maximum annual benefit amount that a Participant (married filing jointly or single head of household) may elect to receive under this Plan in the form of reimbursements for eligible Employment-Related Expenses incurred in any Plan Year (including any related Grace Period) shall be the maximum amount allowed under IRC Section 125 Cafeteria plans. If married and filing separately or single (not head of household), the amount shall be one-half of the maximum amount allowed under IRC Section 125 Cafeteria plans. The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for eligible Employment-Related Expenses incurred in any Plan Year (including any related Grace Period) shall be $60. For subsequent Plan Years, the elected annual benefit amount will remain in effect for the subsequent Plan Year unless the election amount is changed by the Participant during the Open Enrollment Period.

### 7.3 Benefit Premiums; Salary Reduction Contributions

The annual contribution for a Participant's benefits is equal to the annual benefit amount elected by the Participant (for example, if the $5,000 annual benefit amount is elected, the annual contribution amount is also $5,000) or such higher amount allowed per applicable law. The Salary Reduction for each pay period for a Participant is an amount equal to the annual contribution divided by the number of deductible (maximum deductible periods of twelve (12) for monthly pay cycle and twenty (24) for biweekly pay cycle) pay periods remaining in the Plan Year, or an amount otherwise agreed upon. Salary Reductions are applied by the Employer to pay for the contribution for the Participant's benefits, and, for the purposes of this Plan, they are considered employer contributions.

### 7.4 Irrevocability of Election; Changes in Status

Except as described in the State of Florida QSC Event Matrix, a Participant's election under the Premium Payment Component of this Plan is irrevocable for the duration of the Plan Year to which it relates, unless otherwise required by a federal order. In other words, unless one of the QSC Events occurs, a Participant may not change any elections for the duration of the Plan Year regarding participation in the Plan, Salary Reduction amounts, or the election of particular benefits.

Participants may not choose an annual election amount that is less than the amount they have already contributed to their account. (See Section 10.1).

### 7.5 Grace Period

The Grace Period shall be January 1 through March 15 of the year following the end of the Plan Year, or the date extended by federal order, during which amounts unused as of the end of the Plan Year may be used to reimburse Dependent Care Expenses incurred during the Grace Period. To take advantage of the Grace Period, the Employee must be a Participant in the Dependent Care Component on the last day of the Plan Year to which the Grace Period relates.

Eligible expenses incurred during a Grace Period and approved for reimbursement will be paid first from available amounts remaining at the end of the Plan Year to which the Grace Period relates, and then from any amounts that are available to reimburse expenses incurred during the current Plan Year. Claims will be paid in the order in which they are received. This may impact the potential reimbursement of eligible expenses incurred during the Plan Year to which the Grace Period relates to the extent such expenses have not yet been submitted for reimbursement. Previous claims will not be reprocessed or re-characterized as to change the order in which they were received.

### 7.6 Reimbursement Procedure

Under the Dependent Care Component, a Participant may receive reimbursement for eligible Employment-Related Expenses incurred during the Plan Year (including any related Grace Period) for which an election is in force. Payment shall be made to the Participant as reimbursement for eligible Employment-Related Expenses incurred during the Plan Year (including any related Grace Period) for which the Participant's election is effective, subject to substantiation requirements. No payment otherwise due to a Participant hereunder shall exceed the smallest of:

- The year-to-date amount the Participant has had withheld from his Compensation for Dependent Care reimbursement for the Plan Year, less any prior Dependent Care reimbursements during the Plan Year (including any related Grace Period);
- The maximum amount allowed under IRC Section 125 Cafeteria plans, or, if the Participant is married and files a separate tax return, one-half of the maximum amount allowed under IRC Section 125 Cafeteria plans (or any future aggregate limitations promulgated under Code Section 129) less any prior reimbursements during the Plan Year (including any related Grace Period).

A Participant who has elected to receive Dependent Care benefits for a Plan Year may apply for reimbursement by submitting an application in writing to the Administrator or its agent in such form as the Administrator may prescribe, during the Plan Year, but no later than the end of the Run-Out Period for the Plan Year or related Grace Period in which the expense arose, setting forth:

- The person or persons on whose behalf eligible Employment-Related Expenses have been incurred;
- The nature of the expenses so incurred;
- The amount of the requested reimbursement; and
- The application shall be accompanied by bills, invoices or other statements from an independent third party showing the amounts of such expenses, together with any additional documentation which the Administrator or its agent may request.

If a claim is deemed incomplete or insufficient, the Participant must submit additional documentation to the Administrator or its agent, which must be postmarked no later than April 30th for the prior calendar year or the date extended by federal order. Failure to submit a claim or sufficient documentation of a claim by the deadline will result in the forfeiture of the balance of any contributions remaining in a Dependent Care FSA.

As soon as practicable after the Participant submits a reimbursement claim to the Administrator or its agent, the Administrator or its agent will reimburse the Participant for his eligible Employment-Related Expenses (if the Administrator or its agent approved the claim), or the Administrator or its agent will notify the Participant that the claim has been denied.

If a Participant does not submit enough qualified expenses to receive reimbursements for the full amount of coverage elected for a Plan Year by the end of the Run-Out Period following the Plan Year, then the excess amount will be forfeited and applied by the Administrator in accordance with Section 10.1.

### 7.7 Run-Out Period

For the Dependent Care FSA Plan, the Run-Out Period shall begin on January 1 of the year following the Plan Year. For Plan Years 2019-2021, the Run Out Period was extended one year beyond the normal run-out date which was the tax filing deadline for the respective plan year. For Plan Year 2022, the Run Out Period ends on October 23, 2023. For Plan Years beginning with 2023, the Run Out Period ends on April 30. The Run-Out Period end date shall automatically extend based on federal order extending the date for IRC Section 125 Cafeteria plans.

### 7.8 Payment Card

Dependent Care FSA Participants will be issued a payment card that can be used to pay merchants electronically at the point of sale for allowable expenses. The payment card is cancelled once a Participant's employment is terminated.

### 7.9 Reimbursements after Termination

When a Participant ceases to be a Participant under Section 3.3, the Participant's Salary Reductions will terminate, as will his election to receive reimbursements. However, the Participant will be able to receive reimbursements after his participation terminates for eligible Employment-Related Expenses incurred prior to termination and during the Plan Year or related Grace Period, so long as the claims for reimbursements are submitted by the end of the Run-Out Period for the Plan Year.

## ARTICLE VIII HSA COMPONENT

### 8.1 Benefits

An Employee can elect to participate in the HSA Component by electing to pay the contributions on a Pretax Salary Reduction basis to the Participant's HSA established and maintained outside the Plan by a trustee/custodian to which the Employer can forward contributions to be deposited (this funding feature constitutes the HSA benefits offered under this Plan). Such election can be increased, decreased, or revoked prospectively at any time during the Plan Year, effective no later than the first day of the next calendar month following the date that the election change was filed. HSA benefits cannot be elected in combination with Healthcare FSA benefits but may be elected in combination with Limited Purpose FSA benefits.

### 8.2 Contributions for Cost of Coverage for HSA; Maximum Limits

The annual contribution for a Participant's HSA Benefits is equal to the annual benefit amount elected by the Participant, but in no event shall the amount elected exceed the amount established by the IRS for HSA contributions applicable to the Participant's High-Deductible Health Plan coverage option. Any additional catch-up contributions may be made by Participants in accordance with IRS guidance.

An Employee can elect to deposit Shared Savings rewards into an HSA.

### 8.3 Recording Contributions for HSA

As described in Section 8.5, the HSA is not a benefit plan provided by the Employer, Sponsor, or Administrator—it is an individual trust or custodial account separately established and maintained by a trustee/custodian outside the Plan. Consequently, the HSA trustee/custodian, not the Employer, Sponsor, or Administrator, will establish and maintain the HSA. The Plan Administrator will maintain records to keep track of HSA contributions a Participant makes via Pretax Salary Reductions, but it will not create a

separate fund or otherwise segregate assets for this purpose. Any such funds are subjected to be prorated according to the number of pay periods in which funds were deposited.

### 8.4 Tax Treatment of HSA Contributions and Distributions

The federal income tax treatment of the HSA (including contributions and distributions) is governed by Code Section 223.

### 8.5 Reserved

### 8.6 Payment Card

HSA Participants will be issued a payment card that can be used to pay merchants electronically at the point of sale for allowable expenses.

The payment card is cancelled once a Participant's employment is terminated (see below in section 8.7 for information about individual accounts post termination).

### 8.7 Reimbursements After Termination

Participants can continue to use HSA funds after termination through an individual account. There is no time limit for using the funds. Participants will receive a new card for their individual account.

## ARTICLE IX–APPEALS PROCEDURE

### 9.1 Appeals by Participant

The purpose of the appeals procedure is to provide a procedure by which a Participant, under this Plan, may have reasonable opportunity to appeal to the Plan Administrator for a full and fair review of a Healthcare FSA, Limited Purpose FSA or Dependent Care reimbursement denial as well as adverse determinations under the salary reduction aspect of this Plan --such as the ability to make salary reductions on a pre-tax basis (collectively called an FSA Appeal).

Please refer to the plan documents for the Health Insurance Plan, Life Insurance Plan and Supplemental Insurance Plan for claims and appeals procedures under those plans.

A Participant, or the Participant's duly authorized representative, may request an FSA Appeal as follows:

Level I appeals –Send written and signed FSA Claim Appeals, including all pertinent information, documents, and the reason for the appeal, to Chard Snyder, PO Box 618, Fort Washington, PA, 19034, or fax to 888-304-7497. Electronically signed documents are acceptable. A Level 1 Appeal decision will be completed in 30 days.

Level II appeals – Participants who desire to contest an unfavorable Level I appeal decision must submit a Level II appeal to the Plan Administrator, as instructed in the Level I denial letter. Members must submit their appeal to be received by the Plan within 60 days of the Level I appeal denial notice. The Level II appeal should be addressed to the following: Division of State Group Insurance, Attention: Appeals Coordinator, P.O. Box 5450, Tallahassee, FL 32314-5450. The e-mail address is DSGIAppeals@DMS.myflorida.com. The Plan Administrator will provide, by certified mail, any adverse benefit determination to the Participant's address of record in People First.

The Administrator will respond to Level II appeals within the following timeframes from the receipt of the appeal:

Medical/Pharmacy appeals:

- Urgent – within 72 hours
- Pre-Service – within 15 days
- Post-Service – within 30 days.

Eligibility Appeals:
Acknowledgement Letter – within 2 business days and an appeal determination within 21 calendar days

### 9.2 Decision upon Appeal

Participants who desire to contest an unfavorable Level II appeal decision may request an administrative hearing pursuant to Chapter 120, F.S. The petition must be received by the Department within twenty-one (21) calendar days after receipt of the decision by the Participant or within twenty-one (21) calendar days after the date of the last notice of attempted delivery, whichever is earlier, unless this date is extended by federal order, in which case the appeal must be provided in accordance with the federal order.

Participants must send petitions to the Agency Clerk and Hearings Coordinator, Office of General Counsel, Department of Management Services, 4050 Esplanade Way, Suite 160, Tallahassee, FL 32399-0949.

## ARTICLE X – RECORDKEEPING AND ADMINISTRATION

### 10.1 Establishment of Accounts

The Administrator will establish and maintain a Healthcare FSA and Limited Purpose FSA with respect to each Participant who has elected to participate in the Medical Reimbursement Component of the Plan and will establish and maintain a Dependent Care FSA with respect to each Participant who has elected to participate in the Dependent Care Component of the Plan, but will not create a separate fund or otherwise segregate assets for the purpose of keeping track of contributions and determining forfeitures under subsection (c) below.

(a) Crediting of Accounts. A Participant's Healthcare FSA, Limited Purpose FSA, and/or Dependent Care FSA will be credited periodically during each Plan Year with an amount equal to the Participant's Salary Reductions elected by and made by the Participant to be allocated to the respective accounts.

(b) Debiting of Accounts. A Participant's Healthcare FSA, or Limited Purpose FSA will be debited during each Plan Year for any reimbursement of Medical Care Expenses incurred during the Plan Year. Any claims submitted during the Run-Out Period for the prior Plan Year will first be applied to any amounts carried over.

(c) A Participant's Dependent Care FSA will be debited during each Plan Year for any reimbursement of eligible Employment-Related Expenses incurred during the Plan Year. For reimbursement requests of eligible Employment-Related Expenses incurred during a Grace Period for a related Plan Year and submitted prior to the Run-Out Period for the related Plan Year, such reimbursement will first be applied against any unused funds remaining in a Participant's Dependent Care FSA for such Plan Year before being applied against any funds available for reimbursement for the current Plan Year.

(d) Forfeiture of Accounts. If any balance in excess of the maximum Carryover amount remains in the Participant's Healthcare FSA or Limited Purpose FSA after all reimbursements (including during the Run-Out Period) have been made for the Plan Year, the Participant shall forfeit all

rights with respect to such balance. However, if any balance remains in the Participant's Dependent Care FSA for a Plan Year after all reimbursements have been made for the Plan Year and the related Grace Period (including during the Run-Out Period), the Participant shall forfeit all rights with respect to such balance.

(e) All forfeitures under this Plan shall be used first to offset any losses experienced by the Administrator during the Plan Year as a result of making reimbursements (i.e., providing benefits) with respect to any Participant in excess of the premiums paid by such Participant via Salary Reductions; and second, to reduce the Administrator's cost of administering this Plan during the Plan Year (all such administrative costs shall be well documented by the Administrator); and third, to provide increased benefits or Compensation to Participants in subsequent years in any fashion the Administrator deems appropriate, consistent with Treasury Regulation Section 1.125-2, QIA- 7(b)(7) or other similar guidelines. As described in Section 6.2, the amount available for reimbursement of Medical Care Expenses is the Participant's annual benefit amount, plus any amounts carried over, and reduced by prior Plan Year reimbursements; it is not based on the amount credited to the account at a particular point in time. Thus, a Participant's Healthcare FSA or Limited Purpose FSA may have a negative balance during a Plan Year, but any such negative amount shall never exceed the maximum dollar amount of benefits under this Plan elected by the Participant. By contrast, as described in Section 7.6, the amount available for reimbursement of eligible Employment-Related Expenses is limited to the amount credited to the Participant's Dependent Care FSA.

### 10.2 Plan Administrator

The administration of this Plan shall be under the supervision of the Administrator. It is the principal duty of the Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

### 10.3 Powers of the Administrator

The Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties hereunder, including (but not limited to) the following discretionary authority to:

(a) Construe and interpret this Plan and to decide all questions of fact, questions relating to eligibility and participation and questions of benefits under this Plan;
(b) Prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;
(c) Prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Administrator determined to be appropriate;
(d) Request and receive from all Employees and Participants such information as the Administrator shall from time to time determine to be necessary for the proper administration of the Plan;
(e) Furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Administrator determined to be reasonable and appropriate;
(f) Receive, review, and keep on file such reports and information concerning the benefits covered by this Plan as the Administrator determines from time to time to be necessary and proper;
(g) Appoint and employ such individuals or entities to assist in the administration of the Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;
(h) Sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan; and
(i) Maintain the books of accounts, records and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

### 10.4 Election Modifications Required by Administrator

The Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions for a Plan Year if the Administrator determines that such action is necessary or advisable to:

(a) Satisfy any Code's nondiscrimination requirements applicable to this Plan or other cafeteria plan;
(b) Prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized;
(c) Maintain the qualified status of benefits received under this Plan; or
(d) Satisfy Code nondiscrimination requirements or other limitations applicable to an Employer's Code Section 401(k) Plan (e.g., Code Section 415 limitations).

In the event that contributions need to be reduced for a class of Participants, the Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount, continuing with the Participant in the class who had elected the next highest Salary Reduction amount, and so forth, until the defect is corrected.

### 10.5 Named Fiduciary

The Administrator shall be named fiduciary responsible for the Plan. The Administrator may, however, delegate any of its powers and duties in writing to any person or entity. The delegate shall be the fiduciary for only that part of the administration which has been delegated by the Administrator and any reference to the Administrator shall instead apply to the delegate. However, if the Administrator assigns any of the Administrator's responsibilities to an Employee, it will not be considered a delegation of the Administrator's responsibility but rather how the Administrator internally assigns responsibility.

### 10.6 Error Correction

Nothing in this Plan shall be construed to prevent the Administrator from correcting errors in the Participants' benefits or contributions.

## ARTICLE XI – GENERAL PROVISIONS

### 11.1 Expenses

All administrative costs shall be borne by the Sponsor.

All reasonable expenses incurred in administering the Plan are currently paid by forfeitures to the extent provided in Article VI with respect to the Medical Reimbursement Component and Article VII with respect to the Dependent Care Component, and then by the Sponsor. For HSA Benefits, a separate HSA trustee/custodial fee may be assessed by the Participant's HSA trustee/custodian. Any such fees may be paid on behalf of the Participant by the Sponsor or by the State.

### 11.2 Funding this Plan

All amounts payable under this Plan shall be paid from Plan assets. Nothing herein will be construed to require the Sponsor or the Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Plan from which any payment may be made. While the Sponsor has complete responsibility for the payment of benefits, it may hire an outside paying agent to make benefit payments on its behalf.

### 11.3 No Contract of Employment
Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that the Employee will be employed for any specific period of time. All Employees are considered to be employed at the will of the Employer.

### 11.4 Code Compliance
It is intended that this Plan meet all applicable requirements of the Code, and of all regulations issued there under. This Plan shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan and the Code, the provisions of the Code shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict. While this is not an ERISA Plan, the ERISA guidance will be followed under the Medical Reimbursement Component only.

### 11.5 Amendment and Termination
This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Sponsor or Administrator may amend or terminate this Plan at any time, and such amendment or termination will automatically apply to the related Employers that are participating in the Plan.

### 11.6 Governing Law
This Plan shall be construed, administered and enforced according to the laws of the State of Florida, to the extent not superseded by the Code, or other federal law. While this is not an ERISA Plan, the ERISA guidance will be followed under the Medical Reimbursement Component only.

### 11.7 No Guarantee of Tax Consequences
Neither the Administrator nor the Sponsor makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal or state income tax purposes.

### 11.8 Indemnification of Sponsor
If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis and if such payments do not qualify for such treatment under the Code, then such Participant shall indemnify and reimburse the Sponsor for any liability that it may incur for failure to withhold federal income taxes, Social Security taxes or other taxes from such payments or reimbursements.

### 11.9 Non-Assignability of Rights
The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and will not be subject to be taken by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

### 11.10 Gender; Singular and Plural References
A pronoun or adjective in the masculine gender includes the feminine and singular includes the plural unless the context clearly indicates otherwise.

### 11.11 Headings
The headings of the various Articles, Sections, and Subsections are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

**11.12 Plan Provisions Controlling**
In the event that the terms or provisions of any summary or description of this Plan, or of any other instrument, are in any construction interpreted as being in conflict with the provisions of this Plan as herein set forth, the provisions of this Plan shall be controlling.

## ARTICLE XII – HIPAA PRIVACY AND SECURITY

**12.1 Applicability.**
This Article shall only apply to the extent that the Plan or any portion thereof constitutes a group health plan subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The components of the Plan that are not subject to HIPAA shall not be subject to this Article.

**12.2 Definitions.**
For purposes of this Article, the following definitions shall apply:

(a) "Health Care Operations" are as defined under 45 C.F.R. Section 164.501.

(b) "Payment," as defined under 45 C.F.R. Section 164.501, means activities undertaken by the Plan to obtain contributions or to determine or fulfill its responsibility for coverage and provision of benefits, or to obtain or provide reimbursement for the provision of health care.

(c) "Privacy and Security Policy" means the Plan's written policies and procedures implementing the provisions of this Article.

(d) "Protected Health Information" (PHI) means individually identifiable health information that:

(i) relates to the past, present or future physical or mental condition of a current or former Participant, provision of health care to a Participant, or Payment for such health care;

(ii) can either identify the Participant, or there is a reasonable basis to believe the information can be used to identify the Participant; and

(iii) is received, created, maintained or transmitted by or on behalf of the Plan.

**12.3 Privacy and Security Policy.**
The Plan shall adopt a Privacy and Security Policy, the terms of which are incorporated herein by reference, as amended from time to time.

**12.4 Privacy of Participant Medical Information.**
The Plan shall not use or disclose PHI other than as permitted or required by HIPAA and the rules, regulations, and other guidance issued by the U.S. Department of Health and Human Services under HIPAA. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, Payment for health care, and Health Care Operations as set forth in its Privacy and Security Policy.

**12.5 Security of Participant Medical Information.**
The Plan shall put in place administrative, physical, and technical safety measures to reasonably and appropriately protect the confidentiality, integrity, and availability of PHI that is stored electronically, consistent with the requirements of HIPAA, the Health Information Technology for Economic and Clinical Health Act (HITECH), and the rules, regulations, and other guidance issued by the U.S. Department of Health and Human Services under HIPAA and HITECH.

**12.6 Business Associate Agreement.**
The Plan shall enter into a business associate agreement with any persons or entities as may be required by applicable law.

**12.7 Notice of Privacy Practices.**
The Plan shall provide each Participant with a notice of privacy practices to the extent required by applicable law.

**12.8 Reporting of Improper Use or Disclosure.**
The Plan shall comply with the breach of unsecured PHI notification provisions as set forth in HITECH and addressed under Notification in the Case of Breach of Unsecured Protected Health Information at 45 CFR Part 164, Subpart D.

**12.9 Interpretation.**
The Plan and this Article shall be interpreted and administered in accordance with applicable federal or state law, and any other applicable regulation or other official guidance issued thereunder. In the event of a conflict between this Article and a statute, regulation, or guidance, such statute, regulation, or guidance shall govern, according to the hierarchy in section 1.3 above.

**12.10 Certification.**
The Plan Administrator certifies that this Article incorporates the provisions set forth in 45 CFR Section 164.504(f)(2)(ii) and the Plan Administrator agrees to such provisions in accordance with 45 CFR Section 164.504(f)(2)(ii).