State of Florida Salary Reduction Cafeteria Plan with Premium Payment, Health Savings Account (HSA) and Flexible Spending Accounts

ARTICLE I – INTRODUCTION

1.1 Establishment of Plan

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, hereafter known as the State of Florida Salary Reduction Cafeteria Plan ("the Plan"), effective January 1, 2014.

This Plan is designed to permit an Employee to pay by a Salary Reduction Agreement on a Pretax basis for his share of premiums under the Health Insurance Plan, the Life Insurance Plan, Supplemental Insurance Plans and to contribute to a Health Savings Account (HSA) or a 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.

The Health FSA Component is intended to qualify as a self-insured Medical Reimbursement Plan under Code § 105, and the Medical Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code § 105(b). The Dependent Care Reimbursement Account (DCRA) Component is intended to qualify as a Dependent care assistance program under Code § 129, and the Dependent Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code § 129(a).

The Health FSA Component and the DCRA Component are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Codes §§ 105 and 129. The Health FSA 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 HSA funding feature described in the HSA Component is not intended to establish an ERISA plan or to otherwise be part of an ERISA benefit plan.

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

ARTICLE II – DEFINITIONS and CONSTRUCTION

2.1. Definitions

(1) "Administrator" for purposes of this document is the State of Florida, 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) "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

(3) "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 § 401(k), § 403(b) or § 408(k) arrangement.

(4) "Dependent" for purposes of insurance coverage means the Employee's legal spouse, as defined in §741.212(3), F.S.; and through the end of the calendar year in which she or he reaches age 26: the Employee's own children, stepchildren, legally adopted children or children placed in the Employee's home for the purposes of adoption in accordance with Chapter 63, F.S.; children for whom the Employee has been granted court ordered custody or legal guardianship in accordance with Chapter 644, F.S.; foster children; and the newborn child of an eligible, covered child of the Employee. However, for the purpose of the Medical Reimbursement Component, the term "Dependent" includes any individual who is a tax dependent of an Employee as defined in Code §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.

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

(6) "Dependent Care Expenses" means expenses that are 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 Employee and Spouse, if any), if paid for by the Employee to provide Qualifying Dependent Care Services as defined by the Internal Revenue Publication 503.

(7) "Dependent Care Reimbursement Account" means the account described in Article IX of this Plan.

(8) "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.

(9) "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.

(10) "Employer" means the State of Florida.

(11) “Flexible Spending Account” means the Medical Reimbursement Account, Limited Purpose Medical Reimbursement Account and Dependent Care Reimbursement Account.

(12) “Grace Period” means January 1 through March 15 of the calendar year following the Plan Year.

(13) “Health Insurance Plan” means the Plan(s) that the Employer maintains for its Employees (and for their eligible Dependents), providing medical benefits through a group insurance policy or policies (including HMOs and group Supplement offerings), which plan or plans qualify as accident or health plans under Code 106 (other than a long-tem care insurance plan). The Employer 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 (for the Employee, Spouse and/or eligible Dependents) is considered the Employee’s Health Insurance Plan coverage for purposes of this Plan.

(14) “Health Savings Account” or “HSA” means a tax-favored trust or custodial account that the Employee establishes with the qualified HSA Trustee to pay or be reimbursed for eligible medical expenses.

(15) “High Deductible Health Plan” means the High Deductible Health Plan offered by the Employer as a Benefit Package Option under the Medical Insurance Plan that is intended to qualify as a High Deductible Health Plan under Code § 223(c)(2), as described in materials provided separately by the Employer.

(16) “Life Insurance Plan” means the plan(s) that the Employer maintains for its Employees providing life insurance benefits through a group insurance policy or policies, which plan or plans qualify as life insurance plans under Code 79. The Employer 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.

(17) “Limited Purpose Medical Reimbursement Account” means an arrangement under which an Employee may set aside money on a Pretax basis via Salary Reduction to pay for Medical Care Expenses.

(18) “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 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.

(19) “Medical Reimbursement Account” an arrangement under which an Employee may set aside money on a Pretax basis via Salary Reduction to pay for Medical Care Expenses.

(20) “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.

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

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

(23) "Plan Year" means the calendar year commencing on January 1 and ending on December 31.

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

(25) "Pretax" means an arrangement whereby insurance premiums are deducted from the Employee's pay before taxes are calculated.

(26) "Qualifying Status Change Event" or "QSC Event" – as defined in the Qualifying Status Change (QSC) Matrix – means an occurrence that affects eligibility for coverage qualifies an Employee to make an insurance Coverage or Flexible Spending Account change outside of Open Enrollment.

(27) "Salary Reduction Agreement" means an agreement, the terms of which are incorporated herein by reference and made a part hereof, by which a Participant specifies his 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.

(28) "Supplemental Insurance Plan" means the plan(s) that the Employer maintains for its 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). The Employer 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. Each other Employee shall become eligible to participate in the Plan upon employment with the Employer. 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 qualify for Coverage beginning January 1, 2014 are eligible to participate in the Health Insurance Plan, HSA, Life Insurance Plan, Supplemental Insurance Plans and the DCRA.

3.2 Participation

To become a Participant an Employee shall complete, execute and deliver a Salary Reduction Agreement to the Administrator or its agent within sixty (60) calendar days of initial employment with the Employer. 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 the date on which the Participant files a Salary Reduction Agreement with the Administrator or its agent, and the proper salary reductions have been made for the benefit elected, 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 execute and deliver to the Administrator or its agent a 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 delivering a Salary Reduction Agreement to the Administrator or its agent during the Open Enrollment Period for succeeding Plan Years.

3.3 Termination of Participation

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 Employee 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 Employee ceases (because of retirement, death, termination of employment, layoff, reduction in hours or any other reason) to be an Employee 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 Participation Following Termination of Employment

A former Participant who is rehired prior to the last day of the calendar month following the date of a termination of employment will be reinstated with the same elections such individual had before termination. If a former Participant is rehired after the last day of the calendar month following termination of employment and is otherwise eligible to participate in the Plan, the individual may make new elections as a new hire, except that such individual may not enroll or reenroll in the Medical

Reimbursement Component or the Limited Medical Reimbursement Component until the next Open Enrollment Period for any succeeding Plan Year.

3.5 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 Components 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 Employer 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:

- Benefits available to the Participant under a Health Insurance Plan as described in Article V of this Plan;
- Benefits available to the Participant under a Life Insurance Plan as described in Article V of this Plan;
- Benefits available to the Participant under a Supplemental Insurance Plan as described in Article V of this Plan;
- Benefits available to the Participant under a Medical Reimbursement Component as described in article VI of this Plan. OPS Employees are not eligible for this benefit;
- Benefits available to the Participant under a Dependent Care Component as described in Article VII of this Plan;
- Benefits available to the Participant under a Health Savings Account as described in Article VIII of this Plan; and
- Such other benefits as may be made available to Participants by the Employer by amendment hereto.

4.2 Election of Benefits in Lieu of Cash
A Participant may elect under the Plan to receive one or more benefits in accordance with the procedures described in Section 4.4. If a Participant elects a benefit described in Section 4.1(d) and (e), the Participant's Compensation will be reduced 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 Employer 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 Employee'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) 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.

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 (as determined by the Employer) 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 Heath Insurance Plan or Life Insurance Plan under this Premium Payment Component Plan, and for those Employees to whom the benefits of this premium component Plan, 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 be provided not 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 from time to time 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, polices and procedures from time to time 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 from time to time 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 from time to time 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 from time to time 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 from time to time adopted in accordance therewith.

5.6 Irrevocability of Election

Except as described in the QSC 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 applies, the Participant may not change any elections for the duration of the Plan Year regarding participation in this Plan, salary reduction amounts or election of particular benefits.

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 Medical Reimbursement Account or a Limited Purpose Medical Reimbursement Account.

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 (including any related Grace Period) shall be $2,500. 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 (including any related Grace Period) shall be $60. 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 be carried forward by the Administrator and shall be 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 premium for a Participant's benefits is equal to the annual benefit amount elected by the Participant (for example, if the maximum $2,500 annual benefit amount is elected, the annual premium amount is also $2,500 as adjusted for inflation pursuant to Code § 125(i), subject to Section 7.5(c)). 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 and, for the purposes of the Plan, they are considered Employer contributions.

6.4 Irrevocability of Election
Except as described in the QSC 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 applies, the Participant may not change any elections for the duration of the Plan Year regarding Participation in this Plan, Salary Reduction amounts or election of particular Component Plan benefits.

6.5 Grace Period
The Employer has established a Grace Period of January 1 through March 15 following the end of the Plan Year during which amounts unused as of the end of the Plan Year may be used to reimburse Medical Care Expenses incurred during the Grace Period. To take advantage of the Grace Period, the Employee must be a Participant in the Medical Reimbursement 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 so as to change the order in which they were received.

6.6 Reimbursement Procedure

Under the Medical Reimbursement Component, a Participant may receive reimbursement for Medical Care Expenses incurred during the Plan Year and any related Grace Period 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 (reduced by prior reimbursements for the applicable Plan Year and/or related Grace Period) shall be available at all times during the Plan Year and any related Grace Period, regardless of the actual amounts credited to the Participant's Medical Reimbursement Account or Limited Purpose Medical Reimbursement Account pursuant to Section 9.1. 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 6.6.

A Participant who has elected to receive medical reimbursement 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 and, by no later than April 15 following the close of the Plan Year or related Grace Period in which the expense was incurred, setting forth:

- the person or persons on whose behalf the expenses have been incurred;
- the nature of the expenses so 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 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. Except for the final reimbursement claim for a Plan Year or related Grace Period, no claim for reimbursement may be made unless and until the aggregate claims for reimbursement is a least $25.00.

As soon as practicable after the Participant submits a reimbursement claim to the Administrator or its agent, the Employer 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 Participant does not submit enough qualified expenses to receive reimbursements for the full amount of coverage elected for a Plan Year by April 15 following the Plan Year, then the excess amount will be forfeited and applied by the Employer in accordance with Section 9.1.

If improper reimbursement of ineligible Flexible Spending Account 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.*

MRA or LPMRA amounts may not be used to reimburse qualified Dependent Care Expenses.

6.7 Payment Card

MRA and LPMRA Enrollees will be issued a payment card that can be used to pay merchants electronically at the point of sale for allowable expenses. Enrollees will be required to provide documentation substantiating the eligibility of the payment. If documentation is insufficient, these actions, with notice to the Enrollee, will be taken:

- Suspend payment card privileges, which will be reinstated upon substantiation or recoupment;
- Substitute any paper claims filed for reimbursement towards the ineligible or unsubstantiated card payment;
- Accept personal check or money order to clear the ineligible or unsubstantiated expense;
- Initiate payroll deductions to clear the ineligible or unsubstantiated expense;
- Pursue collection of the ineligible expense pursuant to Rule 69I-21.004, F.A.C., which is adopted by reference.

The payment card is cancelled once an Enrollee's employment is terminated.

6.8 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. The Participant will not be able to receive reimbursements for eligible expenses incurred after his 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 April 15 following the close of the Plan Year or related Grace Period in which the expense arose.

To the extent required by federal law (COBRA) (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 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 Employee for unused annual and/or sick leave balances;
- payment of full remaining amount of the election by personal check at the time of termination; or,
- equal 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 (including any related Grace Period) 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 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 $5,000 ($2,550 if married and filing separately). 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 be carried forward by the Administrator and shall be 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 maximum $5,000 annual benefit amount is elected, the annual premium amount is also $5,000). 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, 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 QSC 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 Qualifying Status Change (QSC) Events applies, the 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

No Participant shall be allowed to reduce his election for Dependent Care Component benefits to a point where the annualized contribution for such benefit is less than the amount already reimbursed (see Section 9.1).

7.5 Grace Period
The Employer has established a Grace Period of January 1 through March 15 following the end of the Plan Year during which amounts unused as of the end of the Plan Year may be used to reimburse Medical Care Expenses incurred during the Grace Period. To take advantage of the Grace Period, the Employee must be a Participant in the Medical Reimbursement 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 so 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, provided that the substantiation requirements of Section 7.5 (e) have been complied with. 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 Participant's earned income for the applicable month; or,
- The earned income of the Participant's Spouse for such month (note: a Spouse of a Participant who is not employed during a month in which the Participant incurs eligible Employment-Related Expenses and who is either incapacitated or a student shall be deemed to have earned income in the amount of $200 per month per qualifying individual for whom the Participant incurs eligible Employment-Related Expenses, up to a maximum amount of $400 per month); or $5,000, or, if the Participant is married and files a separate tax return, $2,500 (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 April 15 following the close of 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
- A statement that such expenses have not otherwise been paid and are not expected to be paid through any other source.

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. Except for the final reimbursement claim for a Plan Year or related Grace Period, no claim for reimbursement may be made unless and until the aggregate claims for reimbursement is at least $25.00.

As soon as practicable after the Participant submits a reimbursement claim to the Administrator or its agent, the Employer 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 April 15 following the Plan Year, then the excess amount will be forfeited and applied by the Employer in accordance with Section 9.1.

7.7 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 April 15 following the end of the Plan Year or related Grace Period in which the expense arose.

ARTICLE VIII HSA COMPONENT

8.1 Benefits
An Employee can elect to participate in the Health Savings Account (HSA) Component by electing to pay the Contributions on a Pretax Salary Reduction basis to the Employee'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). As described in Article XII, 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 with Health FSA benefits unless the Limited (Vision/Dental/Preventive Care) Health FSA option is selected. In addition, a Participant who has an election for Health FSA benefits (other than the Limited (Vision/Dental/Preventive Care) Health FSA Option) that is in effect on the last day of a Plan Year cannot elect HSA benefits for any of the first three calendar months following the close of that Plan Year, unless the balance in the Participant's Health FSA Account is $0 as of the last day of that Plan Year.

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 statutory maximum amount 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.

8.3 Recording Contributions for HSA
As described in Section 8.5, the HSA is not an employer-sponsored employee benefit plan—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, will establish and maintain the HSA. The Plan Administrator will maintain records to keep track of HSA Contributions an Employee makes via Pretax Salary Reductions, but it will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over the funds deposited in an HSA.

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 § 223.

8.5 Trust/Custodial Agreement; HSA Not Intended To Be an ERISA Plan
HSA Benefits under this Plan consist solely of the ability to make Contributions to the HSA on a Pretax Salary Reduction basis. Terms and conditions of coverage and benefits (e.g., eligible medical expenses, claims procedures, etc.) will be provided by and are set forth in the HSA, not this Plan. The terms and conditions of each Participant's HSA trust or custodial account are described in the HSA trust or custodial agreement provided by the applicable trustee/custodian to each electing Participant and is not a part of this Plan. The HSA is not an Employer-sponsored Employee benefits plan. It is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of "qualified eligible medical expenses" as set forth in Code § 223(d)(2). The Employer has no authority or control over the funds deposited in a HSA. Even though this Plan may allow Pretax Salary Reduction contributions to an HSA, the HSA is not intended to be an ERISA benefit plan sponsored or maintained by the Employer

ARTICLE IX–APPEALS PROCEDURE

9.1 Appeals by Participant

The purpose of the review procedure set forth herein is to provide a procedure by which a Participant, under this Plan, may have reasonable opportunity to appeal an adverse determination under this Plan to the Administrator for a full and fair review. To accomplish that purpose, the Participant, or the Participant's duly authorized representative, may request:

Level I appeals – Participants are entitled to appeal an adverse determination concerning a benefit claim or request for medical services, supplies or prescription drugs that is totally or partially denied (Benefit Appeal); or a decision regarding enrollment or eligibility to participate in the Program (Eligibility Appeal). Participants must:

- Submit Benefit Appeals in accordance with the instructions and timeframes in the relevant benefit document.
- Send written and signed Eligibility Appeals, including all pertinent information and the reason for the appeal, to People First, Post Office Box 6830, Tallahassee, Florida 32314, or fax to (800) 422-3128. An Eligibility Appeal must be received by People First within 180 calendar days of the Participant's adverse determination.
- Appeal must be received by People First within 180 calendar days of the Participant's adverse determination.

Level II appeals – Participants who desire to contest an unfavorable Level I appeal decision must submit a Level II appeal to the Plan or the Division, as instructed in the Level I denial letter. The Level II appeals submitted to the Division must be received within sixty (60) calendar days of the date of the notice of the Level I decision. The Division will provide by certified mail any adverse benefit determination to the Participant's last known address in People First.

9.2 Decision upon Appeal

Participants who desire to contest an unfavorable Level II appeal decision are allowed to 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. Participants must send petitions to the Office of General Counsel, Department of Management Services, 4050 Esplanade Way, Tallahassee, FL 32399-0949.

Participants who desire to contest an unfavorable Level II Benefit Appeal may be allowed to request a review from an Independent Review Organization. Level II appeal denial notices will include this information as applicable.

ARTICLE X – RECORDKEEPING and ADMINISTRATION

10.1 Establishment of Accounts

The Administrator will establish and maintain a Medical Reimbursement Account or Limited Purpose Medical Reimbursement Account 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 Reimbursement Account 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 Medical Reimbursement Account or Limited Purpose Medical Reimbursement Account and/or Dependent Care Reimbursement Account will be credited periodically during each Plan Year with an amount equal to the Participant's Salary Reductions elected by Participants to be allocated to the respective accounts.

(b) Debiting of Accounts. A Participant's Medical Reimbursement Account or Limited Purpose Medical Reimbursement Account will be debited during each Plan Year for any reimbursement of Medical Care Expenses incurred during the Plan Year. For reimbursement requests of Medical Care 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 Medical Reimbursement Account for such Plan Year before being applied against any funds available for reimbursement for the current Plan Year.

(c) A Participant's Dependent Care Reimbursement Account 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 Reimbursement Account 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 remains in the Participant's Medical Reimbursement Account, Limited Purpose Medical Reimbursement Account and/or Dependent Care Reimbursement Account for a Plan Year after all reimbursements have been made for the Plan Year and the related Grace 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 Employer 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 Employer'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 6.5(b), the amount available for reimbursement of Medical Care Expenses is the Participant's annual benefit amount, 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 Medical Reimbursement Account or Limited Purpose Medical Reimbursement Account 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 7.5(b), the amount available for reimbursement of eligible Employment-Related Expenses is limited to the amount actually

credited to the Participant's Dependent Care Reimbursement Account.

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 in order 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 the Employer's Code Section 401(k) Plans (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.

ARTICLE XI – GENERAL PROVISIONS

11.1 Expenses
All administrative costs shall be borne by the Employer.

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 Employer. For HSA Benefits, a separate HSA trustee/custodial fee may be assessed by the Participant's HSA trustee/custodian. Any such fees shall be the responsibility of the Participant; they will not be paid by the Employer.

11.2 Funding this Plan
All of the amounts payable under this Plan shall be paid from Plan assets. Nothing herein will be construed to require the Employer 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 Employer 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 and ERISA Compliance
It is intended that this Plan meet all applicable requirements of the Code, ERISA and of all regulations issued there under. (ERISA applies to the Medical Reimbursement Component only.) 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 and/or ERISA, the provisions of the Code and ERISA shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

11.5 Amendment and Termination
This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer 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, ERISA or other federal law.

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

11.8 Indemnification of Employer

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 Employer 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.

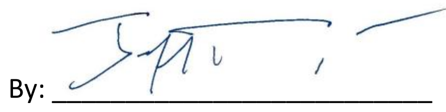
11.10 Gender; Singular and Plural References
A pronoun or adjective in the masculine gender includes the feminine and singular includes the plural, unless the context clearly indicates otherwise.

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.

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the State of Florida Salary Reduction Cafeteria Plan, the Department of Management Services, Division of State Group Insurance has caused this Plan to be executed in its name and on behalf of the State of Florida, on this 29th day of January 2014.

Department of Management Services
Division of State Group Insurance



By: ___________________________
Jeff Dykes
Interim Director of State Group Insurance