SUMMARY PLAN DESCRIPTION

OF

CITY OF PEMBROKE PINES

SECTION 125 - FLEXIBLE BENEFITS PLAN

This Summary Plan Description effective October 1, 2023
Completely revokes and supersedes all prior Summary Plan Descriptions.

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FLEXIBLE BENEFITS PLAN

TABLE OF CONTENTS

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SECTION 125 - FLEXIBLE BENEFITS PLAN

INTRODUCTION

CITY OF PEMBROKE PINES (the "Employer") is proud to present this Summary Plan Description ("SPD") explaining the CITY OF PEMBROKE PINES Section 125 Flexible Benefits Plan (the "Plan") to you. Your well-being and that of your family is important. This Plan is designed to offer you a choice of benefits, allowing you to build a personal benefit program that is tailored to your specific needs. Although a portion of the cost of these benefits is paid by the Employer, one of the Plan's most important features is the special way it allows you to pay for your portion of the cost of the insured benefits with pre-tax dollars, providing a substantial reduction in the cost. Another important Plan feature enables you to use pre-tax dollars to pay for certain tax deductible expenses which would otherwise be paid with after-tax dollars. This also will result in significant savings for you. The Employer wants you to be able to take advantage of every available benefit under the Plan to the extent appropriate for your situation. To do this, you must understand the many options available to you.

This SPD is designed to explain the various options offered under the Plan so that you can make an informed decision regarding your choices. Please read it carefully and keep it in a safe place for reference. This Plan is for you. There are benefits available for every employee and the Employer encourages you to make the most of them. Although this SPD explains the important facts about the Plan, it does not replace the formal Plan Document. In the case of any inconsistency between the Plan Document and this SPD, the Plan Document will govern. Your rights under the Plan are legally enforceable, but oral statements relating to the Plan are not legally binding.

GENERAL INFORMATION

Name of Plan: CITY OF PEMBROKE PINES
Section 125 Flexible Benefits Plan

Plan Number: 501

Plan Type: Section 125 (Cafeteria) Plan

Plan Sponsor: CITY OF PEMBROKE PINES
601 City Center Way
Pembroke Pines, Fl. 33025
(954) 437-1146

Employer Identification No: 59-0908106

Plan Administrator: CITY OF PEMBROKE PINES
601 City Center Way
Pembroke Pines, Fl. 33025
(954) 437-1146

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Plan Fiduciary: Daniel A. Rotstein

Agent For Legal Process: CITY OF PEMBROKE PINES
601 City Center Way
Pembroke Pines, Fl. 33025
(954) 437-1146

DEFINITIONS

"Account" means the account or accounts established on your behalf, based on your elections under the Plan, for the purpose of accounting for your designated contributions and for providing reimbursements to you for qualifying expenses incurred during the Plan Year. The Accounts that may be established include:

(a) Medical Expense Reimbursement Account
(b) Dependent Care Reimbursement Account

"Benefit Dollars" means the amounts, to provide benefits, which are credited to your Account(s) under the Plan.

"Benefit Package Option" means the various insurance coverages that your Employer offers you that can be paid for with pre-tax dollars under this Plan

. Group Medical Insurance
Group Dental Insurance
Group Vision Insurance
Cancer Insurance
Accident Insurance
Hospital Indemnity Insurance

"Dependent" means the following:

For purposes of any Benefit Package Option offered by the Employer, "Dependent" shall be defined under the terms of the insured Benefits Package Option to which it relates, provided the individual also meets one of the criteria below:

1. your child (natural, step or adopted child or a foster child lawfully placed with you) who has not attained age 27 as of the end of the taxable year, regardless of whether the child resides with you, is a student or provides more than ½ of his/her own support, or

2. your child of any age if disabled and incapable of self-care; or

3. a child who is entitled to coverage under one of the Benefits Package Options due to a medical child support order; or

4. any individual (other than your spouse) who bears a relationship to you (provided the relationship does not violate local law), for whom you provide over ½ of his/her support for the calendar year, and who is not the dependent (for tax purposes) of any other individual.

"Effective Date" means October 1, 1997, the date the Plan was established.

"Plan Year" means the 12-month period beginning October 1 and ending September 30. *For the purpose of incurring claims only, it shall also include the 2 month and 15 day period of time beginning on October 1 and ending on December 15 immediately following the end of the preceding plan year.*

PARTICIPATION

You must meet the eligibility requirements of the Plan in order to participate. You may then join the Plan on the "Entry Date" established for all employees. Certain application forms need to be completed before you can enroll in the Plan.

You will be eligible to participate in and begin paying your portion of any group and/or voluntary insurance premiums on a pre-tax basis and the Dependent Care Reimbursement Account and Medical Expense Reimbursement Account on the 31st day of continuous fulltime employment. You must be regularly scheduled to work at least 30 hours per week.

The Entry Date for the Plan is the date eligibility requirements are met and continues 30 days past the entry date.

PLAN OPERATION

If you elect to participate and receive insurance coverage under the insurance plans, and as a result of your participation, you incur a cost for any insurance coverages selected, you will **automatically** become a Participant in this Plan, and will be deemed to have elected to pay any cost of coverage under the insurance plans on a pre-tax basis. This automatic election will also remain effective during each subsequent Plan Year, unless or until you choose to change or revoke that election, either during an open enrollment period or if you have a Change in Status. Furthermore, the amount of your salary reductions for the insurance plans will be automatically adjusted as the cost of coverage under these plans increases or decreases.

You will be given the opportunity to elect not to participate in this portion of the Plan by filing a revocation form with the Plan Administrator. This means that if you choose to participate in an insurance plan, but elect to revoke your participation in this Plan, the cost for any insurance coverage for which you are responsible will be deducted from your pay on an after-tax basis. You may only revoke your election to participate in this Plan when you first become eligible for coverage, prior to the start of any Plan Year during the open enrollment period, or if you have a qualifying Change in Status event.

MEDICAL EXPENSE REIMBURSEMENT ACCOUNT

A deduction against your federal income taxes on your annual federal income tax return is allowed for medical expenses that are greater than 7.5% of your adjusted gross income. Many taxpayers are unable to take advantage of this deduction since medical expenses often fail to reach that level for the average family.

Under the Plan, you may set up a Medical Expense Reimbursement Account to pay uninsured medical expenses. The 7.5% restriction does not apply to this account. This means that nearly all the money you spend for medical expenses can be exempt from taxation.

The reimbursement account is funded with Benefit Dollars. The amount you select is put into an Account in your name each payday. Then, as you incur eligible expenses, you are reimbursed from your Account. The maximum number of Benefit Dollars you can put into a Medical Expense Reimbursement Account is limited to $3,050 per year.

There is no minimum amount. These limits will be reviewed by the Employer annually and may be adjusted, as experience indicates.

Only "eligible expenses" can be reimbursed. To be eligible an expense must be:

1. A tax deductible medical expense or over-the-counter drug or menstrual supplies not covered by insurance or reimbursed by any other source
2. An expense incurred by you, your spouse, or any person who is a Dependent as defined above. An expense shall be considered “incurred” when the service was rendered, and not when you are formally billed, charged for or paid for the expenses.
3. An expense incurred during the Plan Year, and submitted for reimbursement not later than 90 days after the end of the Plan Year.
4. **If any participant shall also be an active participant in a Health Savings Account, Qualifying Medical Expenses shall be limited to dental expenses, vision expenses, expenses considered “preventive” and any expense which would otherwise be defined as a Qualified Medical Care Expense once the statutory deductible of the HSA compatible insurance plan has been met.**

One example of an eligible expense is the amount of out-of-pocket expenses you pay toward satisfaction of your deductible or copayments under the Employer’s group medical insurance plan. Other examples of eligible expenses include the cost for eyeglasses and contact lenses, physical exams, and other expenses not covered by the Employer’s

group insurance policies. You may obtain a more complete list of eligible expenses from the Employer, but remember – to be reimbursable under this Plan, eligible expenses must not be covered by any other insurance. Examples of expenses which are **not** tax deductible, and hence, not considered eligible expenses include elective cosmetic surgery, personal use items such as vitamins or nutritional supplements, and weight loss programs without a physician's diagnosis of obesity. Beginning in 1997, the Internal Revenue Code was modified so that long-term care expenses qualify as medical expenses. However, long-term care expenses may not be reimbursed to you through the Medical Expense Reimbursement Account.

To elect to participate in the Medical Expense Reimbursement Account, indicate on the enrollment form the amount of Benefit Dollars you wish to put into this Account for the Plan Year. The amount of Benefit Dollars elected will be divided by the number of remaining pay dates in the Plan Year, and will be deducted ratably from your paycheck each pay date and allocated to this Account.

As you incur eligible expenses, you may obtain reimbursement from this Account by submitting a claim form to the Plan Administrator (or its designee). You must provide supporting documentation with your claim form describing who received the service, when the expense was incurred, the type of expense, the amount of the expense and who was paid. The supporting documentation must come from the third party provider of the service. Cash register receipts (except as evidence for over-the-counter health-related expenses), canceled checks, credit card slips or credit card bills will not be accepted. If the expense is considered eligible for reimbursement, you will receive a reimbursement and the amount will be recorded in your Account. If the reimbursement request is rejected as not eligible, you will be notified regarding the reasons for its rejection. You must use the procedures described below in the "Claims and Appeals Procedures" section to have a denial reviewed.

Claims must be submitted on the forms provided by the Employer. All taxpayers are responsible for the validity of the information on their tax return. Similarly, you are responsible for making certain, to the best of your ability, that all expenses submitted for reimbursement are eligible expenses. Reimbursements will be processed at least monthly, subject to a minimum amount of $10.00. Reimbursements will always be made payable to you. Claims will be paid up to the total amount you have chosen to put into this Account for the Plan Year, less any previous amounts already reimbursed.

While an expense must be incurred during the Plan Year to be eligible for reimbursement , the actual request for claims reimbursement does not have to be submitted during the Plan Year. ***Claims received during the 90 day period after the end of the Plan Year or your last day of employment, whichever is earlier, will be accepted for payment.*** Claims received later than that will not. The earlier you submit your claims, however, the earlier you will be reimbursed.

Not everyone will want to establish a Medical Expense Reimbursement Account. A form is available to help you estimate your probable eligible expenses so you can decide whether or not an account will be to your advantage. This is very much like preparing your household budget.

YOU SHOULD BE VERY CAREFUL IN MAKING YOUR ESTIMATE BECAUSE YOU WILL FORFEIT ANY MONEY LEFT OVER IN YOUR ACCOUNT AT THE END OF THE PLAN YEAR. A detailed explanation of this appears in the section of this description titled "Special Rules for Reimbursement Accounts." Be sure you read it carefully.

DEPENDENT CARE REIMBURSEMENT ACCOUNT

If you must pay for the care of Qualifying Individuals to allow you to be gainfully employed, then you may be interested in the Dependent Care Reimbursement Account. This Account allows "eligible Employees" with "Qualifying Individuals" to set aside amounts from their pay each pay date on a pre-tax basis to be used to reimburse "eligible expenses."

To be an "eligible Employee," you must satisfy at least one of the following requirements:

1. Both you and your spouse are employed;
2. Your spouse is disabled;

3. Your spouse is a full-time student; or
4. You are single.

A "Qualifying Individual" must live in your home and be one or more of the following:

1. A child under age 13 who bears a relationship to you, who lives with you for more than ½ of the taxable year, and who has not provided over ½ of his or her own support for the taxable year;
2. A dependent parent or other Dependent (provided the relationship between that person and you does not violate local law) who is disabled and regularly spends at least 8 hours a day or more in your home ;
3. Your disabled spouse.

To be an "eligible expense" the money may be paid to any individual or organization other than:

1. Your spouse;
2. Your child under age 19 at calendar year end;
3. Your Dependent for income tax purposes;
4. A childcare facility caring for more than 6 persons but not complying with all state or local requirements.

Examples of "eligible expenses" include those expenses that enable you or your spouse to work or to look for work, such as:

1. Child care or day care centers that care for 6 or more persons, and comply with all state or local licensing requirements;
2. Caregivers for a Qualifying Individual who lives with you;
3. Babysitters;
4. Nursery schools; and
5. Household expenses, provided that a portion of such expenses are incurred to ensure the Qualifying Individual's well-being and protection.

The law places limits on how many Benefit Dollars can be put into a Dependent Care Reimbursement Account for the Plan Year. The limits are:

1. In general, $5,000;
2. However, if you are married and file a separate tax return, the limit is $2,500;
3. Your contribution may not exceed the income of the lower paid spouse and special rules apply when the spouse is a student or is disabled;
4. If you use the tax credit, as explained later, these limits are reduced by the amount of expenses claimed under the tax credit.

The Dependent Care Reimbursement Account is funded with Benefit Dollars. To elect to participate, indicate on the enrollment form the amount of Benefit Dollars you wish to put into this Account for the Plan Year. The amount of Benefit Dollars elected will be divided by the number of remaining pay dates in the Plan Year, and will be deducted ratably from your paycheck each pay date and allocated to this Account.

You will be reimbursed for qualified employment-related dependent care expenses incurred during the Plan Year from the amount credited to your Account at the time the claim is paid, less any prior reimbursements paid. "Incurred" means when the service was provided, and not when you paid for it. You must submit claims on a claim form provided by the Plan Administrator (or its designee) , and you must include the following information:

1. the amount of the claim as evidenced by a paid receipt or other supporting documentation;
2. the name of the Qualifying Individuals;
3. the name, address and tax ID number of the provider; and
4. a statement saying that you will not deduct this expense on your personal income tax return.

Reimbursements, which will be processed at least monthly, are always made payable to the Employee. If there is not enough money in the account to pay you the full amount of any requested reimbursement, a partial payment will be

made and the remaining unpaid amount will be held until it can be paid (i.e. after the Account is again credited with additional salary reduction contributions). Reimbursements will not be processed for less than $10.00, except to close out the Account.

The supporting documentation must come from the third party provider of the service. Cash register receipts, canceled checks, credit card slips or credit card bills will not be accepted.

If your claim is denied, you will receive written notification advising you of the reason for the denial and a description of any additional information needed to reconsider your claim. Requests for reconsideration must be submitted in writing within 60 days after denial.

Only expenses incurred during the Plan Year are eligible for reimbursement under this Account, but it is not required that claims be submitted during the Plan Year. ***Claims received not later than 90 days after the end of the Plan Year or your last day of employment, whichever is earlier, will be accepted***. Claims received later than that will not.

It is your responsibility to make certain, to the best of your ability, that all expenses submitted for reimbursement are eligible expenses. This is the same responsibility all taxpayers have in filing their tax return.

Not all employees will be eligible to establish a Dependent Care Reimbursement Account. If you are eligible, you must estimate how much your dependent care is going to cost. A form will be provided to help you determine if you are eligible and to estimate your eligible expenses.

YOU SHOULD BE VERY CAREFUL IN MAKING YOUR ESTIMATE BECAUSE YOU WILL FORFEIT ANY MONEY LEFT OVER IN THE ACCOUNT AT THE END OF THE PLAN YEAR. This is explained in detail in the section of this description titled "Special Rules for Reimbursement Accounts." Be sure you read it carefully.

Expenses that are eligible for this benefit are also eligible for a tax credit under current tax laws. This is explained in more detail in the section of this description entitled "DEPENDENT CARE ASSISTANCE PROGRAM". Be certain you read it before making any decision relative to establishing a Dependent Care Reimbursement Account. You may not claim the tax credit and use a reimbursement account for the same expenses.

SPECIAL RULES FOR REIMBURSEMENT ACCOUNTS

The special tax status afforded reimbursement accounts has already been explained. In order to take advantage of these unique benefits, several requirements must be satisfied. Noncompliance with the requirements could result in the loss of some or all of your money allocated to your reimbursement accounts. Understanding the rules reduces the chances of this happening. The requirements are:

1. You must enroll in the Account(s) and state the amount you wish to set aside prior to the first day of the Plan Year or the first day you are eligible.
2. Once the Plan Year or your participation has begun, you cannot change the amount for any reason other than due to a “change in status” or certain other events specified in government regulations. A “change in status” is defined in the section of this description titled “CONTRIBUTIONS/ELECTIONS.” The change must be consistent with the type of status change.
3. Any money placed in a reimbursement account becomes the property of the Employer, and can only be paid to you to reimburse eligible expenses.

ANY AMOUNTS LEFT IN YOUR ACCOUNT(S) AT THE END OF THE PLAN YEAR AFTER ALL ELIGIBLE CLAIMS HAVE BEEN PROCESSED ARE FORFEITED AND WILL NOT BE RETURNED TO YOU.

In spite of these requirements, you are encouraged to study the tax benefits that may be derived from using these reimbursement Accounts. Used wisely, you may enjoy significant savings.

DEPENDENT CARE TAX CREDIT

Currently, the amount of federal income taxes (but not Social Secuity/Medicare ("FICA")) you owe may be reduced by a percentage of the money you have spent on eligible dependent care expenses. This is called a Dependent Care Tax Credit. The percentage varies depending on the combined income of you and your spouse. The total amount of expense eligibles for the credit is $3,000 for one child and $6,000 for two or more children.

These expenses are also eligible for payment through the Employer's Dependent Care Reimbursement Account, as described earlier. Since you are not permitted to use both the Dependent Care Tax Credit and the Employer's Dependent Care Reimbursement Account for the same expenses, you should evaluate both possibilities.

If the combined income of you and your spouse is less than $35,000 ($25,000 for a single person) the tax credit may be to your advantage. If your income (or combined income) it is more than that, the reimbursement account will most likely be more advantageous for you. These are very general rules, however, and should not be relied upon solely when making a final decision.

A form is available from your Employer to help you estimate how much of a tax credit you might receive, but you should consider obtaining an opinion from a qualified tax advisor before making a decision. A full explanation of the tax laws as they relate to dependent care expenses is beyond the scope of this description.

A publication providing detailed information on the tax deductibility of dependent care expenses is available from the Internal Revenue Service (See: Publication 503 – Child and Dependent Care Expenses).

HSA BENEFIT

An HSA permits Employees to make pretax contributions to an HSA established and maintained outside of this Plan with the Employee's HSA trustee/custodian. For purposes of this Plan, HSA Benefits consist solely of the ability to make such pretax contributions under this salary reduction Plan.

To participate in the HSA Benefit, you must be an "HSA eligible individual". This means that you are able to contribute to an HSA under the requirements of Code Section 223 and that you have elected qualifying High Deductible Health Plan coverage offered by the Employer and have not elected any disqualifying non-High Deductible Health Plan coverage offered by the Employer or any other source.

If you elect Medical FSA Benefits, you cannot also elect HSA Benefits (or otherwise make contributions to an HSA) unless you have elected the Limited Medical FSA (Vision/Dental/Preventive/Post-deductible) Coverage Option. In the event that an expense is eligible for reimbursement under both the Medical FSA and the HSA, you may seek reimbursement from either the Medical FSA or the HSA, but not both.

CONTRIBUTION/ELECTIONS

In compliance with federal law, the Plan must allow participants to make changes to their benefit elections at least once each year. Under this Plan, you will be provided an "annual election period" every 12 months (or a shorter period if this is the Plan's first Plan Year) in which to make any additions, deletions or changes to your benefits. In order to participate in the Dependent Care Reimbursement Account or the Medical Expense Reimbursement Account, you must make a new election prior to the start of each new Plan Year if you wish to participate in these Accounts for the upcoming Plan Year.

For each new Plan Year, you may change your previous year's elections. You may also choose not to participate for the upcoming year. If you do not make new elections during the "annual election period" before a new Plan Year begins, you will be considered to have elected to continue your participation for the upcoming Plan Year only for the payment of any premiums for group insured benefits.

Generally, you may not change your elections during the Plan Year, until the new Plan Year. However, there are certain limited situations in which you can change your elections. These situations are listed under 1-8 below. **You must notify the Administrator within 30 days of the event, as specified below**.

1. ***Change in status***. If there is a Change in your status (as described below), you may change your election in a manner which is consistent with the Change in status. If you wish to change your election as a result of a Change in status, you must notify the Plan Administrator (or its designee) in writing within 30 days from the date of the Change in status. The following are considered Change in status events:

    a) Change in legal marital status (through marriage, divorce, annulment, or death of spouse);
    b) Change in the number of Dependents (through birth, death, adoption or placement for adoption of Dependent);
    c) Dependent satisfying or ceasing to satisfy the eligibility requirements of a benefit;
    d) Change by employee, spouse or Dependent in employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite. A change in employment includes a change in status (such as non-salaried to salaried position) which results in the individual becoming eligible or ineligible for this Plan or other related employee benefit plans of the Employer;
    e) Change in place of residence by employee, spouse or Dependent;
    f) If you, your spouse, or Dependent becomes eligible for COBRA continuation coverage (or continuation coverage under any similar state law), the Plan will permit you to elect to increase payments under this Plan in order to pay for the continuation coverage ;
    g) (applicable to medical coverage only) Your hours of service are reduced so that you are expected to average less than 30 hours of service per week, but remain eligible for medical coverage under the employer's group health plan, and you and your enrolled spouse or Dependents will enroll in another plan that provides "minimum essential coverage" (as defined by federal law) with coverage effective no later than the first day of the second month following the month in which your medical coverage under the group medical plan is terminated. Under no circumstances may a participant elect to revoke coverage on a retroactive basis.
    h) (applicable to medical coverage only) You are eligible for special enrollment or annual enrollment under the Marketplace rules and would like to cease coverage under the group medical plan in order to purchase medical coverage from the Marketplace established by the Affordable Care Act (ACA) and you and your enrolled spouse or Dependents will enroll in Marketplace coverage with coverage effective no later than the day after your group medical coverage is terminated . Under no circumstances may a participant elect to revoke coverage on a retroactive basis.

2. ***HIPAA event***. Under the Health Insurance Portability and Accountability Act ("HIPAA") there are certain events which permit you a time period in which you can make a special enrollment election for new coverage or increased medical coverage under a health plan. If you do not elect coverage within this special enrollment election period, you must wait until the next annual election period offered under the Plan (normally prior to the beginning of each new Plan Year). The events which permit a special enrollment election, and the time periods in which you can elect such coverage are as follows:

    a) *The birth or adoption of a child*. If you are covered under the employer's health plan, within 30 days of the birth or adoption (including placement for adoption) of a child, you may change your coverage to include the child. Typically this means that you can increase your coverage (e.g. expand coverage for you and your spouse to family coverage). If you enroll within the 30-day period following the birth, adoption, or placement for adoption, coverage under the Plan for your child will be effective on the date of the birth, adoption, or placement for adoption.
    b) *Marriage*. If you are covered under the employer's health plans, within 30 days of your marriage, you may elect to add coverage for your new spouse (but you cannot use the marriage as the basis for deselecting coverage for yourself, unless you elect coverage under your spouse's employer plan). If you enroll your spouse within 30 days of your marriage, your spouse's coverage will become effective the first day of the month following the date of enrollment.
    c) *Previously declined coverage because of spouse's coverage*. If you are covered under your spouse's health plan, within 30 days of when you would otherwise lose coverage under your spouse's plan, you may elect coverage under the Employer's health plan, if you meet the following two conditions–

(i) You previously declined health plan coverage because you were covered under your spouse's coverage and you are now losing that coverage, and you are losing that coverage because it was COBRA continuation coverage which is exhausted, or because of a legal separation, divorce, death, termination of employment (or reduction in hours of employment), or because employer contributions towards the coverage are being terminated.

(ii) If required to do so by your Employer, you stated in writing at the time you declined coverage under the Employer's health plan that coverage under your spouse's group health plan or health insurance coverage was the reason for declining enrollment. (This requirement applies only if you were required to make such a statement at that time and provided with a notice of that requirement and the consequences of that requirement.)

If this loss of health coverage exception applies to you and you enroll within the special 30-day period, you will be covered on the first day of the month following your enrollment.

3. ***Judgment decree or order regarding your child or dependent foster child***. A change in election will be permitted for a judgment, decree, or order resulting from a divorce, legal separation annulment, or change in legal custody that requires you to provide accident or health coverage for your child or a foster child who is a Dependent, if--

    a) The order requires coverage for the child under the Employer's health plan and you elect to have coverage provided under this Plan, or
    b) The order requires the spouse, former spouse, or other individual to provide health coverage for the child and you elect to cancel coverage for the child.

4. ***Medicare eligibility or loss of eligibility***. If you, your spouse, or Dependent are enrolled in the health plan and you, your spouse, or Dependent become eligible for Medicare coverage, you may make a prospective election to change, cancel or reduce coverage for that individual. If you, your spouse, or Dependent are eligible for Medicare and that eligibility is lost, you may then elect prospectively to begin or increase coverage for that individual.

5. ***Changes in cost or coverage***. You will automatically have your election changed or will be able to change your election for any of the reasons listed in a) through e) below: The election changes permitted under this paragraph 5 do not apply to the Medical Expense Reimbursement Account.

    a) If the cost of coverage under a Benefit Package Option increases or decreases, your salary allocation elections under this Plan will be increased or decreased automatically. Such adjustments will only be made for relatively minor changes in the cost of coverage and only to the extent you would be required to pay such increases in after-tax dollars if they were not covered by your Plan election.
    b) If there is a significant increase in the cost of a Benefit Package Option, you will be permitted to increase the amount of your payments under this Plan. Alternatively, you will be able to revoke your existing benefit election for that Benefit Package Option and elect, on a prospective basis, another Benefit Package Option which provides similar coverage (for example, an HMO instead of health insurance). However, for increases in dependent care expenses, you will <u>not</u> be given these choices if the person providing the dependent care is related to you (including a parent, son, daughter, in-law, brother or sister or step- or half-brother or sister).
    c) If a Benefit Package Option under the Plan is significantly reduced or eliminated and you have chosen that Benefit Package Option, you will be permitted to revoke your election under the Plan and to elect, on a prospective basis, another benefit package option containing similar coverage.
    d) If a Benefit Package Option is added, you will be given the option prospectively to elect it and to elect to pay for the Benefit Package Option on a pre-tax basis, if applicable. You will also be given the option of electing to revoke any of your existing benefits which provides similar coverage.
    e) If there is a change in the coverage of a spouse or Dependent under another employer's plan, you

may make a prospective election change that is on account of and corresponds with a change made from the plan of the employer of the spouse, former spouse, or Dependent, if–

(i) The cafeteria plan or plan which provides benefits of a type permitted under a cafeteria plan of the spouse's, former spouse's, or Dependent's employer permits participants to make an election change that would be permitted under paragraphs 1-6 under this CONTRIBUTIONS/ELECTIONS heading; or
(ii) The period of coverage under the cafeteria plan or plan which provides benefits permitted under a cafeteria plan of the spouse's, former spouse's, or Dependent's employer is different than the period of coverage for which an election is permitted under this Plan (for example, this Plan permits an election on a calendar year basis and the other employer's plan permits an election effective each April 1).

6. ***Family Medical Leave Act (FMLA)***. If you take leave under the Family and Medical Leave Act of 1993 ("FMLA"), you may revoke or change your elections under the Plan as described below. If you continue your health coverage during your paid FMLA leave, your payroll deductions will continue. If you continue your health coverage during your unpaid FMLA leave, you must pay your employee contribution for this coverage either 1) before you go on leave, 2) monthly, while you are on leave, or 3) upon your return from leave. Check the company's employee handbook and ask the human resources and leave administration personnel for more information. If you stop participating in coverage due to revocation of your election or due to your non-payment of contributions while on FMLA leave, you will be permitted to reinstate your coverage for the remainder of the Plan Year upon your return, provided you return to work during or immediately after the period of FMLA protection.

You may continue to participate in the health FSA during your FMLA leave or you may revoke your coverage and resume it when you return. Upon return to work, you can resume your health FSA coverage at its original level and make-up payments for the time that you were on leave. Alternatively, your health FSA election will be reduced proportionately for the time that you were gone and any health expenses you incur during the time you were not participating in the health FSA during your leave are not reimbursable.

7. ***Children's Health Insurance Program Reorganization Act of 2009.*** Effective April 1, 2009, if an otherwise eligible employee (1) loses coverage under a Medicaid Plan under Title XIX of the Social Security Act; (2) loses coverage under State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act; or (3) becomes eligible for group health plan premium assistance under Medicaid or SCHIP, the employee is entitled to special enrollment rights under a Benefit Plan Option that is a group health plan and an election change to correspond with the special enrollment right is permitted. Thus, for example, if an otherwise eligible Employee declined enrollment in medical coverage for the Employee or the Employee's eligible Dependents because of medical coverage under Medicaid or SCHIP and eligibility for such coverage is subsequently lost, the Employee may be able to elect medical coverage under a Benefit Option for the Employee and his or her eligible Dependents who lost such coverage. Furthermore, if an otherwise eligible employee and/or dependent gains eligibility for group health plan premium assistance from SCHIP or Medicaid, the employee may also be able to enroll the Employee, and the Employee's Dependent, provided that a request for enrollment is made within the 60 days from the date of the loss of other coverage or eligibility for premium assistance.

8. ***Effective for Plan Years beginning on or after January 1, 2023***, you or a member of your family group covered by the Plan may decide that one or more of you would prefer to be covered by medical coverage provided through an Exchange. Depending on the income of you or the family member, you or the family member might find that a tax credit was offered if you or the family member were covered by a medical plan provided through an Exchange, rather than one provided by the Employer. In that case, you or the family member can give notice that you or the family member terminate coverage under this Plan, provided that you or the family member must be immediately covered by a medical plan provided by an Exchange.

ADMINISTRATIVE AUTHORITY

The Employer or Plan Administrator may terminate or modify Plan benefits at any time, subject to the provisions of any insurance contracts providing benefits described herein. We will not be liable to you if an insurance company fails to provide any of the benefits.

BENEFIT PAYMENTS - INSURANCE

The amount that you elect to contribute to the Plan will be used to pay your portion of any premiums for elected Benefit Package Options available through the Employer. The insurance policy provisions of each Benefit Package Option will determine what and when benefits will be paid to you.

However, because this Plan permits the payment of premiums for coverage offered under the Employer's group health plan and the group health plan may offer maternity and newborn coverage, you are advised that under federal law, the group health plan may not restrict benefits (or fail to provide reimbursement) for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require authorization from the group health plan or its administrator or the insurance issuer for prescribing a length of stay not in excess of the above periods. However, federal law does not prohibit a mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the 48 hours (or 96 hours as applicable).

Under the Mental Health Parity Act (MHPA) of 1996, as amended, if your Employer had more than an average of 50 employees on all business days during the preceding calendar year, generally this Plan must provide the same lifetime and annual limit for mental health benefits coverage as it does for other health benefits (medical/surgical outpatient benefits). However, this lifetime limit requirement will not apply if the result of the increased lifetime limit is to increase the costs of the Employer's health plan by at least 1%.

In addition, "The Women's Health and Cancer Rights Act" requires group health plans to make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

The Employer's group health plan complies with these requirements. Benefits for these items generally are comparable to those provided under our Plans for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by consultation between the attending physician and the patient. Our Plans neither impose penalties (for example, by reducing or limiting reimbursements) nor provide incentives to induce attending providers to provide care inconsistent with these requirements.

FORFEITURES

If you have any remaining balance in your Dependent Care Reimbursement Account or Medical Expense Reimbursement Account at the end of the Plan Year, you will have a 90-day grace period following the end of the Plan Year in which to submit claims incurred during the Plan Year for reimbursement. **Remember, the service has to be incurred before the end of the Plan Year**. After the 90 days, any remaining balance in these Accounts will be forfeited. That is why it is important to be conservative when making your elections at the beginning of the Plan Year.

TERMINATION OF EMPLOYMENT

Should you leave the Employer's employ during the Plan Year, your right to benefits will be determined in the

following manner:

1. For the insured Benefits Package Options, you will remain covered by insurance, but only for the period for which premiums have been paid prior to your termination of employment.
2. For the Medical Expense Reimbursement Account, you will be able to claim reimbursement for expenses incurred prior to your termination of employment. Claims must be received no later than 90 days following your date of termination. Any Account balance remaining beyond 90 days following your termination will be forfeited. You may also have health continuation rights, as discussed further below.
3. For the Dependent Care Reimbursement Account, you will be able to continue to submit claims for reimbursement of eligible dependent care expenses incurred prior to your termination of employment. Claims must be received within 90 days of your termination. Any Account balance remaining beyond 90 days following your termination will be forfeited.

COBRA CONTINUATION COVERAGE RIGHTS

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of healthcare flexible spending account coverage under the Plan. **This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your health FSA coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their health FSA coverage. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of health FSA coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the health FSA is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the health FSA because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the health FSA because any of the following qualifying events happens:

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

Your dependent children will become qualified beneficiaries if they lose coverage under the health FSA because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;

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

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs (within 30 days of loss of Social Security disability status). An untimely Qualified Event Notice is considered to have no effect and shall be rejected.

The Plan requires that you provide the Qualifying Event Notice in writing by mail to the Plan Administrator. Under no circumstances will an oral notice be effective.

In the Qualifying Event Notice, you are required to provide certain information regarding the qualifying event such as an identification of the type of event, the date the event occurred and the name of the individual to whom the event is applicable. The qualifying events listed below require specific documentation attached to the Qualifying Event Notice:

Qualifying Event	Documentation Required with Notice
Divorce or legal separation	Certified copy of the court order granting the divorce or legal separation.
Death of covered employee	Copy of death certificate.
Qualification for Social Security Disability	Copy of the Social Security Administration determination
Loss of Social Security Disability Status	Copy of Social Security Administration final determination.

To be considered valid, the notice must be completed in full and all required enclosures must be supplied. However, the Plan provides that a Qualifying Event Notice otherwise received timely, but which does not contain all required information or enclosures will not be considered untimely if the Plan Administrator is able to identify the Plan, identify the covered employee or qualified beneficiary, identify the qualifying event or disability, and identify the date on which the qualifying event occurred. The Plan Administrator, in such event, may require additional supplementary information from the covered employee or qualified beneficiary. The completed Qualifying Event Notice must be mailed to the Plan Administrator at the address listed in this SPD. It is recommended that you send the completed Qualifying Event Notice by registered mail, return receipt requested, but it is not required. When you submit a completed Qualifying Event Notice, you need to retain a copy (including copies of all enclosures) and any proof of mailing. If you do not receive a response from the Plan Administrator within 14 days of mailing the notice, you must contact Daniel Rotstein immediately in writing to determine the status of your COBRA claim.

Second-Chance COBRA Election

If you are an employee eligible to receive Trade Adjustment Assistance (TAA) benefits, and you (i) lost health FSA coverage due to a job loss that resulted in eligibility for TAA benefits, and (ii) failed to elect COBRA during your original COBRA election period, you may be entitled to a second 60-day COBRA election period. The new election

period begins on the first day of the month in which you are certified for TAA benefits, but your election must be made within six months of the initial loss of group health coverage. In addition, the petition for trade assistance benefit certification must not have been filed before November 4, 2002.

You may make an election under the second 60-day election period by completing the COBRA Election Notice which you can request by contacting the Plan Administrator and returning it to the Plan Administrator at the indicated address, within the 60-day period and before expiration of the six month eligibility period. If you elect COBRA under this "second-chance" provision, your maximum period of continuation coverage will be based on the date of your original qualifying event. Your coverage will begin on the first day of the 60-day "second-chance" election period. The COBRA Election Notice will provide you with additional information regarding electing COBRA during this second-chance period.

The Trade Act of 2002 allows certain individuals who become eligible for trade adjustment assistance and certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) to take advantage of the Health Coverage Tax Credit. Under the tax provisions, eligible individuals can either take a tax credit or get advance payment of a specified percentage of premiums paid for qualified health insurance, including continuation coverage and, under COBRA, you may be eligible for an extension of COBRA continuation coverage if your COBRA continuation coverage would otherwise end on or after November 20, 2011. Assistance Eligible Individuals who elected the premium reduction under ARRA will not be eligible for the Health Coverage Tax Credit for the months in which they receive a premium reduction.

How Is COBRA Coverage Provided?

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

The COBRA continuation coverage period that applies to certain health care reimbursement plans may not be the same as the COBRA continuation period that applies to other health care benefits as described above, but may end as of the last day of the Plan Year in which the qualifying event occurs. This is discussed further in the subsection entitled *COBRA Coverage for Employees Participating in a Health Care Reimbursement Plan*, below.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. To notify the Plan Administrator of the determination by the Social Security Administration that you, your spouse or your dependent is eligible for disability, a Qualifying Event Notice must be completed and returned to the Plan Administrator. A copy of the determination by the Social Security Administration must be attached to the Qualifying Event Notice.

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

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

COBRA Coverage for Employees Participating in a Health Care Reimbursement Plan

If you are an employee participating in a health care reimbursement plan, such as a flexible spending arrangement (or health reimbursement FSA, which is funded in whole or in part through pre-tax payroll deductions) or a health reimbursement arrangement (or HRA, which is funded solely through employer contributions), COBRA continuation coverage may apply to you and may apply to your qualified beneficiaries.

Generally, most health FSA plans meet certain conditions with respect to maximum benefits and benefit availability and are "excepted" from certain COBRA requirements. If your FSA is an "excepted" plan, you, or your qualified beneficiaries, may have limited COBRA continuation coverage with respect to the health FSA. Your eligibility for this limited COBRA continuation coverage will be determined based on how much of your annual reimbursement amount has been distributed to you as of the date of the qualifying event. COBRA coverage will not be offered to you if you have "overspent" your excepted health FSA as of the date of your qualifying event. Also, for excepted health FSAs, the limited health FSA COBRA continuation coverage period available to qualified beneficiaries who have not overspent their health FSA ends as of the end of the Plan Year in which the qualifying event occurs.

A health FSA is an excepted health FSA if health plan eligibility, the benefits paid to participants and the cost of these benefits to the participants meet three requirements. First, the maximum benefit payable to each participant (the total amount of reimbursement available for the year) cannot exceed the greater of (a) the participant's salary reduction amount for the year times two, or (b) the salary reduction amount for the year plus $500. Second, the employer must offer other major medical plan coverage and this other coverage must be consistently available to all employees who are eligible to participate in the health FSA. Third, the maximum COBRA premium amount for a year must equal or exceed the maximum benefit available under the health FSA for the year.

Health care reimbursement plans that do not meet the conditions listed in the preceding paragraph are "non-excepted" plans. Non-excepted plans include most HRA plans and certain health FSA plans. If you are a participant in a "non-excepted" health care reimbursement plan, you, or your qualified beneficiary, will be eligible for COBRA continuation coverage for the entire applicable COBRA period.

If you have any questions concerning your COBRA continuation coverage with respect to the health care reimbursement plan in which you are participating, you should contact the Plan Administrator.

<u>If You Have Questions</u>

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at <u>www.dol.gov/ebsa</u>. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

<u>Keep Your Plan Informed of Address Changes</u>

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

STATEMENT OF ERISA RIGHTS

As a participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”) . ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration (“EBSA”).

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day, for each day after 30 days that you did not receive the materials, until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. No action at law or in equity may be brought to recover under this Plan until the appeal rights herein provided have been exercised and the Plan benefits requested in such appeal have been denied in whole or in part. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

CLAIMS PROCEDURE - GENERAL

(a) Insured Benefits. All claims for benefits that are provided through insurance contracts, whether such contracts are between the insurer and the Employer or the insurer and you, shall be made by filing a claim for benefits in accordance with the claims procedure set forth under the insurance contract. Neither the Plan Administrator nor the Employer has the authority or responsibility for processing, reviewing or paying such claims. All disputes regarding those claims shall be resolved in accordance with the procedure set forth in the separate description concerning those benefits.

(b) Reimbursement Accounts. With respect to all benefits provided under the Plan through reimbursement Accounts, a claim for benefits shall be made by filing a written request with the Plan Administrator (or its designee), on such forms as the Plan Administrator shall establish. The Plan Administrator may require that the claim be supported by receipts or other evidence substantiating the amount of the expenditure and the character of the claim. You may not use canceled checks, charge card receipts or cash register receipts as substantiation. The Plan Administrator will review the claim and within a reasonable period of time (not to exceed 30 days after the receipt of the claim) notify the claimant of the disposition of the claim. If the claim is honored, then the Plan Administrator will make payment to the participant for the amount of the claim. If the Plan Administrator denies the claim in whole or in part, it will provide written notice to the claimant of the denial of the claim and such notice will set forth (i) the specific reason or reasons for the adverse determination; (ii) reference to the specific Plan provisions on which the benefit determination is based; (iii) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; (iv) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; (v) an explanation that a full and fair review by the Plan Administrator of the decision denying the claim may be requested by the claimant or his authorized representative by filing with the Plan Administrator, within 60 days (180 days for Medical Expense Reimbursement Account claims) after such notice of denial has been received, a written request for such review.

IN THE CASE OF ANY BENEFIT PROVIDED UNDER THE PLAN BY REIMBURSEMENT, ALL CLAIMS FOR REIMBURSEMENT FOR EXPENSES INCURRED WITH RESPECT TO A PLAN YEAR MUST BE SUBMITTED TO THE PLAN ADMINISTRATOR NO LATER THAN 90 DAYS FOLLOWING THE END OF THE PLAN YEAR OR YOUR DATE OF TERMINATION, WHICHEVER IS EARLIER. CLAIMS SUBMITTED AFTER THAT DATE WILL NOT BE PAID.

The Plan Administrator shall review any denied claim upon timely filed request of the claimant within 60 days after receipt of a written request for review, unless special circumstances require an extension of time for processing, in which case the decision shall be rendered as soon as possible but not later than 120 days after receipt of the written request for review. If such an extension of time for review is required because of special circumstances, written notice of the extension shall be furnished to the claimant prior to the commencement of the extension. The decision on review will be in writing, will include specific reasons for the decision and will be furnished to the claimant within the time indicated above. If the decision on review is not furnished within such time, the claim shall be deemed denied on review. In any cases in which a participant establishes that he will incur fixed periodic expenses with respect to which the participant elected to be reimbursed under the Plan, the Plan Administrator may, upon receipt of such assurances and substantiation of those expenses as the Plan Administrator deems appropriate, make periodic reimbursements to the claimant as those expenses are incurred. In such cases, the Plan Administrator may, in its sole discretion, excuse the participant from making claims for reimbursement for some or all of those expenses.

PRIVACY OF HEALTH INFORMATION

This section describes the medical information privacy practices of the Medical Expense Reimbursement Account portion of the Plan, and that of any third party that assists in the administration of the Plan's group health claims, and is effective April 14, 2004, or the effective date of the Plan, whichever is later. For a more complete explanation, see the "Notice of Privacy Practices" which was given to you in connection with these rights. Questions about the Plan's privacy practices should be addressed to the Plan's Privacy Official who is Daniel A. Rotstein and who may be contacted at CITY OF PEMBROKE PINES, 601 City Center Way Pembroke Pines, Fl. 33025 (954) 437-1146.

Our Pledge Regarding Medical Information

The Plan is committed to protecting medical information about you. The Plan may disclose protected health information to the Employer under limited circumstances, although this information will be disclosed only upon the receipt of a certification by the Employer that the Plan documents have been amended to incorporate the privacy provisions, and that it will abide by them.

The Plan may disclose summary health information to the Employer for the purposes of obtaining premium bids, insurance coverage, or modifying, amending, or terminating the Plan.

The Plan may disclose protected health information to carry out Plan administration functions that are consistent under applicable law. The Plan may not disclose protected health information to the Employer for the purpose of employment-related actions or decisions in connection with other benefits or employee benefit plans of the Employer.

A limited number of employees of the Employer will have access to protected health information for the purposes of carrying out Plan administration functions in the ordinary course of business.

How the Plan May Use and Disclose Medical Information About You

The following categories describe different ways that the Plan uses and discloses protected health information. Not every use or disclosure in a category will be listed. However, all of the ways the Plan is permitted to use and disclose information will fall within one of the categories.

For Treatment. The Plan may use or disclose medical information about you to provide you with medical treatment or services by providers. The Plan may disclose protected health information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you at the hospital. For example, the Plan might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is contraindicative with prior prescriptions.

For Payment. The Plan may use and disclose protected health information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, the Plan may share protected health information with a utilization review or precertification service provider. Likewise, the Plan may share protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. The Plan may use and disclose protected health information about you for other Plan operations which are necessary to run the Plan. For example, the Plan may use protected health information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

As Required By Law. The Plan will disclose protected health information about you when required to do so by federal, state or local law. For example, the Plan may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.

To Avert a Serious Threat to Health or Safety. The Plan may use and disclose protected health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, the

Plan may disclose protected health information about you in a proceeding regarding the licensure of a physician.

To Facilitate Claims Under Employer Plans. Your health information may be disclosed to another health plan maintained by the Employer for purposes of paying claims under that plan. In addition, medical information may be disclosed to the Employer to administer benefits under the Plan, such as to determine a claims appeal.

Provide You With Information. The Plan or its agents may contact you to remind you about appointments or provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Organ and Tissue Donation. If you are an organ donor, the Plan may release your medical information to organizations that handle organ procurement or organ, eye or tissue transplants, or to an organ donation bank to help with organ or tissue donation.

Military and Veterans. If you are a member of the armed forces, the Plan may release protected health information about you as required by military command authorities. The Plan may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Public Health Risks. The Plan may disclose protected health information about you for public health activities. These activities generally include the following: to prevent or control disease, injury or disability; to report births and deaths; to report child abuse or neglect; to report reactions to medications or problems with products; to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; or to notify the appropriate government authority if the Plan believes a participant has been the victim of abuse, neglect or domestic violence. The Plan will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. The Plan may disclose protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, the Plan may disclose protected health information about you in response to a court or administrative order. The Plan may also disclose protected health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. The Plan may release protected health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain limited circumstances, the Plan is unable to obtain the person's agreement; about a death the Plan believes may be the result of criminal conduct; about criminal conduct at the hospital; and in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. The Plan may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also release protected health information about you to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. The Plan may release protected health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Your Rights Regarding Medical Information About You

You have the following rights regarding protected health information the Plan maintains about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. If you request a copy of the information, the Plan may charge a fee for the costs copying, mailing, or other supplies associated your request. The Plan may deny your request to inspect and copy in certain limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

Right to Amend. If you feel that medical information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" where such disclosure was made for any purpose other than treatment, payment, or health care operations. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2004. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, the Plan may charge you for the costs of providing the list. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information the Plan uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information the Plan discloses about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that the Plan not use or disclose information about a surgery you had. The Plan is not required to agree to your request however.

Right to Request Confidential Communications. You have the right to request that the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that the Plan only contact you at work or by mail. The Plan will not ask you the reason for your request. The Plan will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

You will not be retaliated against for exercising the privacy rights described above.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by the above discussion or the laws that apply to the Plan will be made only with your written permission. If you provide the Plan permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, the Plan will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that the Plan is unable to take back any disclosures the Plan has already made with your permission, and that the Plan is required to retain its records of the benefits that the Plan provided to you.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

Each group health plan must provide benefits in accordance with the applicable requirements of any qualified medical child support order. A "medical child support order" (MCSO) is an order, decree, or judgment of a court of competent jurisdiction which (i) is made pursuant to a state domestic relations law (including a community property law) and provides for child support with respect to a child of a participant under a group health plan or provides for health benefit coverage to the child under the group health plan; or (ii) enforces a law relating to medical child support described in Social Security Act § 1908 which respect to a group health plan.

A "qualified medical child support order" (QMCSO) is a medical child support order which (i) creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a participant or beneficiary is eligible under a group health plan, (ii) provides certain required information with respect to the order, and (iii) does not require the Plan to provide benefits not otherwise available under the Plan, except to the extent necessary to meet the requirements of Social Security Act § 1908.

The order must clearly state—

(i) the name and the last known mailing address (if any) of the participant and the name and mailing address of each alternate recipient covered by the order (however, the name and mailing address of the state or political subdivision thereof may be substituted),
(ii) a reasonable description of the type of coverage to be provided by the Plan to each such alternate recipient, or the manner in which such type of coverage is to be determined,
(iii) the period to which such order applies, and
(iv) each plan to which such order applies.

Certain procedural requirements are prescribed. The Plan Administrator must promptly notify the participant and each alternate recipient of the receipt of a medical child support order and the Plan's procedures for determining

whether medical child support orders are QMCSOs. Within a reasonable period after receipt of the order the Plan Administrator must determine whether the order is a QMCSO and notify the participant and each alternate recipient of the determination. Each group health plan must establish reasonable procedures to determine whether medical child support orders are QMCSOs. Such a procedure must be in writing, provide notification to each person specified in a MCSO as eligible to receive plan benefits, and permit an alternate recipient to designate a representative for receipt of copies of notices with respect to the MCSO.

NO GUARANTEE OF BENEFITS

Neither the Plan Administrator, nor the Employer, in any way guarantees the payment of any benefit or amount which may become due pursuant to the terms of this Agreement to any participant, terminated participant or beneficiary thereof. Neither the Plan Administrator nor the Employer guarantees the payment by any issuing insurance company of any benefit or amount that may be due under any contract.

The establishment of this Plan does not give any participant or other person any legal right against the Employer or any of its officers or employees or against the Plan Administrator or any insurance company except as herein provided or as provided in the terms of any insurance contract. Under no circumstances shall the terms of employment of any participant be modified or in any way affected by the enactment of this Plan, nor shall participation in this Plan give any employee the right to be retained in the Employer's service or any right or interest in the Plan other than as is herein provided.