Summary Plan Description

City of Jacksonville
Employee Health and Welfare Plan

Effective: January 1, 2023
Group Number: B3267

Administered by Florida Blue

LANGUAGE ASSISTANCE SERVICES

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-904-255-5616 (TTY: 1-904-255-5475).

French Creole (Haitian Creole)
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-904-255-5616 (TTY: 1-904-255-5475).

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-904-255-5616 (TTY: 1-904-255-5475).

Portuguese
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-904-255-5616 (TTY: 1-904-255-5475).

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-904-255-5616 (TTY：1-904-255-5475）。

French
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-904-255-5616 (ATS : 1-904-255-5475).

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-904-255-5616 (TTY: 1-904-255-5475).

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-904-255-5616 (телетайп: 1-904-255-5475).

Arabic
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم -رقم هاتف الصم والبكم:)1-904-255-5475)

Italian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-904-255-5616 (TTY: 1-904-255-5475).

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-904-255-5616 (TTY: 1-904-255-5475).

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-904-255-5616 (TTY: 1-904-255-5475)번으로 전화해 주십시오.

Polish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-904-255-5616 (TTY: 1-904-255-5475).

Gujarati
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-904-255-5616 (TTY: 1-904-255-5475).

Thai
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-904-**255-5616** (TTY: 1-904-255-5475).

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SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Florida Blue City of Jacksonville Service Representative: (904) 255-5570
- Claims submittal address: Florida Blue - Claims
  P.O. Box 1798
  Jacksonville, Florida 32231
- Online assistance: **www.floridablue.com**.

The City of Jacksonville (the "City") is pleased to provide you with this Summary Plan Description (the "SPD"), which generally describes the health benefits available to you and your covered family members under the City of Jacksonville Employee Health and Welfare Plan (the "Plan"). Incorporated by reference into this SPD is another document, known as the "Benefit Booklet" (which may include amendments and/or Endorsements), that provides further information about the particular benefits available to you under the coverage you choose. Taken together, this document and the applicable Benefit Booklet constitute the Plan document. Except where otherwise provided herein, if there should be a conflict between the contents of this document and the contents of the applicable Benefit Booklet with respect to Covered Services and/or benefits available to you, your rights shall be determined under the applicable Benefit Booklet.

You can find copies of the SPD, Benefit Booklets, and any future amendments, updates or Endorsements thereto, by accessing the City's Compensation and Benefits website at http://www.coj.net/Benefits. You may also request printed copies by contacting Employee Benefits.

Because this Plan is sponsored by a governmental entity, it is not subject to the Employee Retirement Security Act of 1974 ("ERISA"). This SPD supersedes any previous printed or electronic SPD for this Plan.

The City reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice. Neither you, your spouse, your dependents, your beneficiaries nor any other person have or will have a vested or nonforfeitable right to receive benefits under the Plan. The Plan does not confer any employment rights, and neither this document, the Benefit Booklet, nor any other document relevant to the Plan should be construed as a contract for employment.

Please read this document and the applicable Benefit Booklet thoroughly to learn how the Plan works. If you have questions, contact the City's Employee Benefits Division or call the number on your ID card.

Capitalized terms not defined in this document are defined in the applicable Benefit Booklet.

SECTION 2 – ELIGIBILITY, ENROLLMENT AND COST

Eligibility

You are eligible to enroll in the Plan if you are a regular full-time employee of a Participating Employer who is scheduled to work at least 30 hours per week, a qualified part-time employee of a Participating Employer, or an eligible retiree of a Participating Employer.

The Participating Employers are:

- City of Jacksonville;
- Jacksonville Housing Authority;
- Northeast Florida Regional Planning Council; and
- First Coast Workforce Development, Inc.

Employees covered by a collective bargaining agreement are not eligible to participate in the Plan unless such collective bargaining agreement provides for participation in the Plan.

A qualified part-time employee is a part-time employee of a Participating Employer who:

- Is represented by Bargaining Unit 179 of the America Federation of State, County and Municipal Employees, AFL-CIO (AFSCME);
- Works in one of the following job categories: OP7CL, OP7SM, OP7TS, 3T7TS, OW7CL, 3P7CB or 3T7CB; and
- Is covered by a collective bargaining agreement that provides for participation in the Plan.

Notwithstanding the foregoing, independent contractors, leased employees, and any other individuals who are not reported on the payroll records of a Participating Employer as common law employees will not be eligible to participate in the Plan. Such individuals are excluded from Plan participation even if a court or administrative agency determines that such individuals are common law employees of a Participating Employer.

An eligible retiree is a former employee who has ended his or service to the City (or another Participating Employer) and is eligible, by IRS tax rules or related City Code, to receive, or has begun receiving, a retirement allowance and/or other benefits from the City's retirement system. Contact your Plan Administrator if you would like more information on the conditions for becoming an eligible retiree.

Your eligible dependents may also participate in the Plan. An eligible dependent is considered to be:

- Your spouse (defined as the person to whom you are legally married); or
- You or your spouse's child who is under age 26, including a natural child, stepchild, foster child, a legally adopted child, a child placed for adoption or a child for whom you or your spouse are the legal guardian; or

- Your over-age dependent child – you or your spouse's child from the age of 26 through the end of the year in which they turn 30 years old, including a natural child, stepchild, foster child, a legally adopted child, a child placed for adoption or a child for whom you or your spouse are the legal guardian who meet all of the following eligibility criteria:
    - He/she is unmarried; and
    - He/she has no dependents of his/her own (i.e. children); and
    - He/she is dependent on an employee for financial support; and
    - He/she is not provided coverage or covered under any other group or individual benefit plan; and
    - He/she is not entitled to benefits under Title XVIII of the Social Security Act; and
    - He/she is a resident of Florida or is a full or part-time student; or
- Your over-age dependent child with a disability – an unmarried enrolled dependent child age 26 or over who is:
    - Incapable of self-sustaining employment because of an intellectual or physical disability; and
    - Chiefly dependent upon you for support and maintenance; or
- A newborn of a Covered Dependent (other than the employee's spouse) is covered for 18 months from the date of birth as long as:
    - The baby is born while the Covered Dependent is covered under the Plan,
    - The Covered Dependent remains covered under the Plan, and
    - You request enrollment of the newborn on the Plan within 60 days of the date of birth.

  At the end of the 18 month period, coverage for the newborn will be terminated and will not be eligible for conversion.

Note: Your dependents may not enroll in the Plan unless you are also enrolled. If you and your spouse are both covered under the Plan, you may each be enrolled as an employee or be covered as a dependent of the other person, but not both. In addition, if you and your spouse are both covered under the Plan, only one parent may enroll your child as a dependent.

A dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described later in this document.

Domestic partners are not considered dependents and therefore are not covered under the Plan.

Cost of Coverage

You and the City share in the cost of the Plan. Your contribution amount depends on the coverage option you select, the family members you choose to enroll and your collective bargaining unit (if applicable).

If you are an employee, your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld - and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Your contributions are subject to review and the City reserves the right to change your contribution amount at any time and from time to time.

You can obtain current contribution rates by calling the City's Employee Benefits Division or by logging into the Employee Portal.

How to Enroll

To enroll, call the City's Employee Benefits Division before the first of the month after your hire date. If you do not enroll by the first of the month after date of hire, you will be defaulted into the UF Health plan single coverage which has no cost for the employee. You will have to wait until the next Annual Enrollment to change your benefit elections.

Each year during the Annual Enrollment, you have the opportunity to review and change your medical election. Any changes you make during the Annual Enrollment will become effective the following January 1st.

Important:

If you wish to change your benefit elections following a marriage, birth, adoption of a child, placement for adoption of a child or other qualified status change, you must contact the City's Employee Benefit Division within 60 calendar days of the event. Otherwise, you will lose the opportunity to change your benefits and will have to wait until the next Annual Enrollment period.

When Coverage Begins

Once the City's Employee Benefits Division receives your properly completed enrollment, your coverage will begin on the first day of the month following your employment date. If you employment date is the first day of the month, your benefits will be effective on your employment date. Coverage for your dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a spouse or dependent stepchild that you acquire via marriage becomes effective the next pay period after you submit the appropriate documentation to Employee Benefits to elect enrollment for the spouse or dependent, provided you notify the City's Employee Benefits Division within 60 calendar days of your marriage. Coverage for dependent children acquired through birth, adoption, or placement for adoption is effective on the date of the status change, provided you notify the City's Employee Benefits Division within 60 calendar days of the birth, adoption, or placement.

Changing Your Coverage

You may make coverage changes during the year if you experience a change in status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). The following are considered status changes for purposes of the Plan:

- Events that change your legal marital status, including marriage, divorce, death of a spouse, legal separation or annulment.

- Events that change your number of dependents, including birth, adoption, placement for adoption, or death of a dependent.
- Any of the following events that change your employment status, or the employment status of your spouse or your dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of your employer, your spouse's employer, or your dependent's employer depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection.
- An event that causes your dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance.
- A change in your place of residence, or the place of residence of your spouse or dependent, that would lead to a change in status (such as a loss of HMO coverage).
- An election that corresponds with the special enrollment rights provided in Internal Revenue Code Section 9801(f), including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (SCHIP); provided that you meet the sixty (60) day notice requirement imposed by Internal Revenue Code Section 9801(f). Such change shall take place on a prospective basis, unless otherwise required by Internal Revenue Code Section 9801(f) to be retroactive.
- You, your spouse, or your dependent become entitled to coverage (i.e., enrolled) under Part A or Part B of the Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). If you, your spouse, or your dependent who has been entitled to Medicaid or Medicare coverage lose eligibility, that individual may prospectively elect coverage under the Plan if a benefit package option under the Plan provides similar coverage.
- If the cost you pay for benefits under the Plan increases significantly, you will be permitted to either make corresponding changes in your payments or revoke your elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage (if applicable), or drop coverage prospectively if there is no benefit package option with similar coverage.
- If the coverage under the Plan is significantly curtailed or ceases during a Plan Year, you may revoke your elections and, in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage (if applicable), or drop coverage prospectively if no similar coverage is offered.
- If, during the period of coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then you may elect the newly-added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage.
- You may make a prospective election change to add coverage under the Plan for yourself, your spouse, or your dependent, if such individual loses group health coverage sponsored by a governmental or educational institution, including a state

children's health insurance program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.
- Any other change in status permitted pursuant to regulations promulgated by the Secretary of the Treasury.

Furthermore, you may prospectively revoke coverage under the Plan provided the following conditions are met:

Conditions for revocation due to reduction in hours of service:

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

The Plan Administrator may rely on your reasonable representation that you and the related individuals have enrolled or intend to enroll in another plan that provides minimum essential coverage for new coverage that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

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

- You are eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace (federal or state exchange) pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or you seek to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and
- The revocation of the election of coverage under the Plan corresponds to your intended enrollment (and the enrollment of any related individuals who cease coverage due to the revocation) in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

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

- One or more related individuals are eligible for a special enrollment period to enroll in a QHP through an Exchange pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or one or more already-covered related individuals seeks to enroll in a QHP during the Exchange's annual open enrollment period; and

- The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the related individual or related individuals in a QHP through an Exchange for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked. If the employee does not enroll in a QHP through an Exchange as set forth in Notice 2014-55, the employee must elect self-only coverage (or family coverage including one or more already-covered related individuals) under the group health plan.

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

Unless otherwise noted above, if you wish to change your elections, you must contact the City's Employee Benefits Division within 60 calendar days of the change in status. Otherwise, you will need to wait until the next Annual Enrollment.

Notice of HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 60 days after you or your dependents' coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself or your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

You also may have special enrollment rights under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). These rights occur when an employee or dependent child

- loses eligibility for coverage under Medicaid or a State Children's Health Insurance Program (acronym "CHIP," for children whose families do not qualify for Medicaid); or

- becomes eligible for premium assistance from Medicaid or CHIP allowing him or her to enroll in a group health plan.

However, you must request enrollment within 60 days after the date of coverage loss or eligibility for Medicaid or CHIP premium assistance, whichever applies.

To request special enrollment or obtain more information, contact the City's Employee Benefits Divison.

SECTION 3 - HOW THE PLAN WORKS

Accessing In-Network and Out-of-Network Benefits

The Plan offers you the choice between HMO and PPO coverage options. It is your responsibility to choose the coverage option that is right for you. You should review the Benefit Booklet for each option for more information on how coverage works.

HMO Coverage

Under a HMO, you and your Covered Dependents can access medical providers only from the HMO network. Generally, there is no Out-of-Network coverage under a HMO plan except in the event of an emergency. As an HMO participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer from the HMO network each time you need to receive Covered Services. The choices you make affect the amounts you pay, as well as the level of benefits you receive and any benefit limitations that may apply.

PPO Coverage

Under a PPO, you and your Covered Dependents can access medical providers from the PPO network or choose to go outside of the network for services. As a PPO participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer from the PPO network each time you need to receive Covered Services. You can choose to receive In-Network or Out-of-Network benefits. However, the amount the Plan covers is generally more for In-Network benefits than for Out-of-Network benefits, so your out-of-pocket expenses are generally less for In-Network benefits. The choices you make affect the amounts you pay, as well as the level of benefits you receive and any benefit limitations that may apply.

Florida law prohibits Out-of-Network Providers from balance billing you for differences between the providers' billed charges and the eligible expense described in the Benefit Booklet for (1) emergency health services provided by an Out-of-Network Provider; and (2) non-emergency services provided by an Out-of-Network provider at an In-Network facility when you did not have an opportunity to select an In-Network Provider (e.g. radiologist, anesthesiologist, pathologist and emergency room physician). You are still responsible for payment of all applicable copayments, coinsurance, and deductibles.

Deductible

The Deductible is the amount you must pay each calendar year for Covered Services before the Plan begins to pay benefits. There are separate In-Network and Out-of-Network Deductibles for the PPO coverage option. Amounts you pay toward your Deductible accumulate over the course of the calendar year. Refer to your Benefit Booklet for more information.

Copayment

A copayment is a set dollar amount for Covered Services that you are responsible for paying. Your Benefit Booklet provides the copayment amount for each Covered Service. Copayments do not apply to the Deductible, but they do go toward the accumulation of the Plan's Out-Of-Pocket maximum. Refer to your Benefit Booklet for more information.

Coinsurance

Coinsurance is the percentage of Covered Services that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Services after you meet the Deductible. Coinsurance does not apply to the Deductible, but it does go toward the accumulation of the Plan's Out-Of-Pocket maximum. Refer to your Benefit Booklet for more information.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Services. Refer to your Benefit Booklet for more information. In the PPO, there are separate In-Network and Out-of-Network Out-of-Pocket Maximums. The amounts you pay for eligible expenses charged by Out-of-Network providers will be applied to both your Out-of-Network Out-of-Pocket Maximums and your In-Network Out-of-Pocket Maximums.

SECTION 4 – COVERED SERVICES & EXCLUSIONS

Refer to your Benefit Booklet for information on which services are covered and which services are excluded.

SECTION 5 - CLAIMS PROCEDURES

In general, if you receive Covered Services from an In-Network Provider, the Claims Administrator will pay the Physician or facility directly. If an In-Network Provider bills you for any Covered Service other than your Copayment or Coinsurance, please contact the provider or call the Claims Administrator at the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Deductible and paying any Copayment or Coinsurance owed to an In-Network provider at the time of service, or when you receive a bill from the provider.

If you receive a bill for Covered Services from an Out-of-Network Provider, you (or the provider if they prefer) must send the bill to the Claims Administrator for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to the Claims Administrator at the address on the back of your ID card.

For more information on how to file a claim, refer to your Benefit Booklet.

If you feel an error has occurred in your records or in processing your claim for benefits, you should know that claims and appeals procedures are available to every participant and beneficiary in the applicable Benefit Booklet. Your claim(s) for benefits will be processed according to the procedures set out in the applicable Benefit Booklet. If the Benefit Booklet does not provide claims procedures or such claims procedures are not in compliance with applicable law, then your claims for benefits will be processed in accordance with the Plan's procedures.

The Plan Administrator has delegated to the Claims Administrator the authority to administer and make final determinations concerning all claims for benefits and appeals of denied claims for benefits; provided that the Plan Administrator has final authority to determine claims and appeals.

You also have the right under the Plan to request an external review in accordance with the provisions of the Benefit Booklet.

To the extent the Benefit Booklet provides for voluntary levels of appeal, the Plan agrees (i) to waive the right to assert that you failed to exhaust your administrative remedies by not submitting the dispute to the voluntary level of appeal; (ii) that the statute of limitation will be tolled during the time that such voluntary level of appeal is pending; and (iii) that you may elect to submit the benefit dispute to the voluntary level of appeal only after you have exhausted the appeals permitted under Department of Labor regulations.

If the Plan Administrator learns of conflicting benefit claims made by two or more claimants, the benefit may be withheld until the conflict is resolved by one of the following: (a) agreement between the claimants; (b) a final judicial determination of entitlement to benefits; or (c) any other procedure reasonably calculated to protect the Plan from paying the same benefit more than once. If there is both a conflict between claimants and a dispute between one of those claimants and the Plan regarding benefit payment, the Plan Administrator may allow the processing of the request for benefits under normal appeal procedures before resolving the conflict between claimants.

You cannot bring any legal action against the Plan, the City, or the Plan Administrator to recover reimbursement until 60 days after you have properly submitted a claim as described in the Benefit Booklet and all required reviews of your claim have been completed. Notwithstanding anything to the contrary in the Benefit Booklet or any other document, if you want to bring a legal action against the Plan, the City, or the Plan Administrator, you must do so within three years from the expiration of the time period in which a claim must be submitted or you lose any rights to bring such an action.

Notwithstanding anything to the contrary in the Benefit Booklet or any other document, you cannot bring any legal action against the Plan, the City, or the Plan Administrator for any other reason unless you first exhaust all steps required in the claims and appeal process. After completing that process, and notwithstanding anything to the contrary in the Benefit Booklet or any other document, if you want to bring a legal action against the Plan, the City, or the Plan Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action.

SECTION 6 – SUBROGATION AND RIGHT OF RECOVERY

This Plan has a right to subrogation. The right of subrogation means the Plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the Plan. Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The Plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Furthermore, whenever the Plan has made payments in excess of the maximum provided for under the Plan, the City, the Plan and/or the Claims Administrator will have the right to recover any such

payments, to the extent of such excess, from you or any other person, plan, or organization that received such payments.

If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery.

The provisions of this section apply to all current or former Plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the Plan. The Plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the Plan pays benefits. No adult Covered Person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult Covered Person without the prior express written consent of the Plan.

The Plan's right of subrogation or reimbursement, as set forth below, extends to all insurance coverage available to you due to an injury, illness or condition for which the Plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage).

The Plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the Plan's subrogation and reimbursement interests are fully satisfied.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the Plan's subrogation and reimbursement interests are fully satisfied.

Lien Rights

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the Plan.

Assignment

In order to secure the Plan's recovery rights, you agree to assign to the Plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

By accepting benefits from the Plan, you acknowledge that the Plan's recovery rights are a first priority claim and are to be repaid to the Plan before you receive any recovery for your damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the Plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The Plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from *any and all* settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The Plan's claim will not be reduced due to your own negligence.

Cooperation

You agree to cooperate fully with the Plan's efforts to recover benefits paid. It is your duty to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents agree to provide the Plan or its representative's notice of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights or failure to reimburse the Plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the Plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the Plan's subrogation or recovery interest or prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from

making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the Plan's subrogation and reimbursement interests.

You acknowledge that the Plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the Plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 *et seq*, to share your personal health information in exercising its subrogation and reimbursement rights.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Plan Administrator (or its delegate) shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the Plan incurs in successful attempts to recover amounts the Plan is entitled to under this section.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes, you should pay the excess back promptly. Otherwise, to the extent allowed under applicable law, the City may recover the amount in the form of salary, wages, or benefits payable under any City-sponsored benefit plans, including this Plan. The Plan also reserves the right to recover any overpayment by legal action or by offsetting payments on future eligible expenses.

If the Plan overpays a health care provider, the Plan and the Claims Administrator reserve the right to recover the excess amount, by legal action if necessary.

If the Plan pays for benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;

- all or some of the payment the Plan made exceeded the amount that should have been paid under the Plan; or
- all or some of the payment was made in error.

The refund equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Plan may reduce the amount of any future benefits for the Covered Person that are payable under the Plan. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future benefits.

SECTION 7 - WHEN COVERAGE ENDS

Your entitlement to benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, the Plan will still pay claims for Covered Services that you received before your coverage ended. However, once your coverage ends, benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

Your coverage under the Plan will end on the earliest of:

- If your termination date is the first of the month through the 15th, your benefits will end at midnight on the 15th;
- If your termination date is the 16th of the month through the 30th or 31st, your benefits will end at midnight of the 30th or 31st;
- The date the Plan ends;
- The last day of the benefit period (15th or the last day of the month) you stop making the required contributions;
- The last day of the benefit period (15th or the last day of the month) you are no longer eligible;
- The last day of the benefit period (15th or the last day of the month) the Claims Administrator receives written notice from the City to end your coverage, or the date requested in the notice, if later; or
- The last day of the benefit period (15th or the last day of the month) you retire or are pensioned under the Plan, unless specific coverage is available for retired or pensioned persons, and you are eligible for that coverage.

Coverage for your eligible dependents will end on the earliest of:

- The date your coverage ends;
- The last day of the benefit period (15th or the last day of the month) you stop making the required contributions;
- The last day of the benefit period (15th or the last day of the month) the Claims Administrator receives written notice from the City to end your coverage, or the date requested in the notice, if later; or

- The last day of the benefit period (15th or the last day of the month) your dependents no longer qualify as dependents under this Plan.

The Plan may also cancel your coverage for cause under the circumstances described in your Benefits Booklet. Refer to your Benefits Booklet for more information.

Rescission of Coverage
The Plan will not rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. For purposes of this provision, a rescission is a cancellation or discontinuance of coverage that has retroactive effect.

Coverage for a Disabled Child
If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

- The child is unable to be self-supporting due to a mental or physical handicap or disability;
- The child depends mainly on you for support;
- You provide to the Plan proof of the child's incapacity and dependency within 60 days of the date coverage would have otherwise ended because the child reached a certain age; and
- You provide proof, upon the Plan's request, that the child continues to meet these conditions.

The proof might include medical examinations at the City's expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 60 days, the Plan will no longer pay Benefits for that child. Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

Continuing Coverage through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a qualifying event:

- An employee; or
- An employee's enrolled dependent, including with respect to the employee's children, a child born to or placed for adoption with the employee during a period of continuation coverage under federal law.

Qualifying Events for Continuation Coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage[1]	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below
The City files for bankruptcy under Title 11, United States Code[2]	36 months	36 months[3]	36 months[3]

[1]Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a) the determination of the disability, b) the date of the qualifying event, c) the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

[2]This is a qualifying event for any retired employee and his or her enrolled dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy

was filed.

[3]From the date of the employee's death if the employee dies during the continuation coverage.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your dependents' COBRA coverage is impacted if you become entitled to Medicare:

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare and don't experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

* Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Employee and Employer costs, plus a 2% administrative fee and other cost as permitted by law. Note, however, that the cost for COBRA Coverage provided during the disability extension described above is the full cost, including both Employee and Employer costs, plus a 50% administrative fee and other costs as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the Plan under COBRA, you have the right to change your coverage election:

- During Annual Enrollment

- Following a change in status.

Notification Requirements

If your Covered Dependents lose coverage due to divorce, legal separation, or loss of dependent status, you or your dependents must notify the Plan Administrator within 60 days of the latest of:

- The date of the divorce, legal separation or an enrolled dependent's loss of eligibility as an enrolled dependent
- The date your enrolled dependent would lose coverage under the Plan
- The date on which you or your enrolled dependent are informed of your obligation to provide notice and the procedures for providing such notice

You or your dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage. If you or your dependents fail to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child. Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide Employee Benefits with notice of the Social Security Administration's determination within the latest of 60 days after a) the determination of the disability, b) the date of the qualifying event, c) the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in this SPD. The contents of the notice must be such that the Plan Administrator is able to determine the covered employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

When COBRA Ends

COBRA coverage will end before the maximum continuation period shown above if:

- You or your Covered Dependent becomes covered under another group medical plan, as long as the other plan doesn't limit your coverage due to a preexisting condition; or if the other plan does exclude coverage due to your preexisting condition, your COBRA benefits would end when the exclusion period ends;
- You or your Covered Dependent becomes entitled to, and enrolls in, Medicare after electing COBRA;
- The first required premium is not paid within 45 days;
- Any other monthly premium is not paid within 30 days of its due date;
- The entire Plan ends; or

- Coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

Family and Medical Leave Act

Notwithstanding any other provision of the Plan, if you take an approved leave of absence under the FMLA, coverage under the Plan will continue to be made available during such leave period to you and your Covered Dependents under the same terms and conditions that coverage was made available immediately prior to the commencement of the leave. If you do not wish to continue these benefits during the FMLA leave, you must inform Employee Benefits before the start of the leave.

If you elect to continue your coverage during such a leave period, you must continue to pay any required employee-portion of the cost of the level of coverage elected. If any portion of the leave period is paid leave, the employee-portion of the cost of coverage will continue to be deducted from your pay on a pre-tax basis in accordance with your election. Upon returning from an approved FMLA leave, coverage under the Plan will immediately resume regardless of whether you elected to continue coverage during the FMLA leave.

City Contributions. While you are on an FMLA leave, the City will continue to make the same contributions toward the cost of coverage continued under the Plan that it would have made had you not taken such leave of absence. The City will continue to do so until the earlier of the date that (a) you fail to return to work on the expiration of the FMLA leave, or (b) you voluntarily give notice of your intent to terminate employment. For these purposes, you are considered to "terminate employment" when you give oral or written notice of your intent not to return to work due to reasons within your control.

If you voluntarily terminate your employment due to reasons within your control at or before the end of the FMLA leave, the City shall have the right to be reimbursed by you for any and all contributions the City has made on behalf of you and your Covered Dependents during the leave. In this regard, the City shall have the right to obtain reimbursement from any funds that the City might otherwise owe you following the voluntary termination, including (but not limited to) (a) any regular or overtime wages, commissions, salary, or bonuses; (b) accrued paid time off ("PTO"); or (c) other sources in accordance with state law. In addition, the City shall have the right to pursue reimbursement in a court of law. Regardless of whether or not you return from an FMLA leave, the City shall be entitled to recover from you any required employee contributions the City has made on behalf of you and your Covered Dependents during the unpaid leave to ensure continuity of coverage.

The City may not recover any of its regular contributions made on behalf of you and your Covered Dependents for the time you had been on an FMLA leave if your failure to return to employment at the expiration or exhaustion of such leave is due to (a) the continuation, recurrence, or onset of a serious health condition that would entitle you to the FMLA leave; or (b) other circumstances beyond your control (as set forth in the City's policies and procedures).

Covered Employee Options. As soon as administratively feasible after you qualify for an FMLA leave, the Plan Administrator shall give you the opportunity to choose in writing between continued coverage during the leave of absence, or suspending coverage for the leave's duration. If you choose ongoing coverage, you must continue to make the same premium payments or contributions that you were making immediately before the leave took effect, as described above.

The City will send a letter explaining your share of the cost of coverage. You must pay premiums within the time period provided in the letter, and any applicable grace period, or your coverage may be terminated, and you will not be able to re-enroll until the next Open Enrollment Period.

The obligation to provide ongoing coverage under this Plan for you and your Covered Dependents on an FMLA leave, if any, ceases if you are more than thirty (30) days late on making a required premium payment; provided, however, that the City may—at its option—cover your missed payments so that coverage will be uninterrupted. In this event, the City's advances may be recovered in the event you voluntarily terminate your employment under circumstances within your control.

Uniformed Services Employment and Reemployment Rights Act

An employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the employee and the employee's dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, employees may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on an employee's behalf. If an employee's Military Service is for a period of time less than 31 days, the employee may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

An employee may continue Plan coverage under USERRA for up to the lesser of:

- The 24 month period beginning on the date of the employee's absence from work; or
- The day after the date on which the employee fails to apply for, or return to, a position of employment.

Regardless of whether an employee continues health coverage, if the employee returns to a position of employment, the employee's health coverage and that of the employee's eligible dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on an employee or the employee's eligible Dependents in connection with this reinstatement, unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

SECTION 8 - OTHER IMPORTANT INFORMATION

Qualified Medical Child Support Orders (QMCSOs)
A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with the Claims Administrator and the Plan Administrator
In order to make choices about your health care coverage and treatment, the Plan Administrator believes that it is important for you to understand how the Claims Administrator interacts with the Plan and how it may affect you.

The Claims Administrator helps administer the Plan in which you are enrolled. The Claims Administrator does not provide medical services or make treatment decisions. This means:

- The Plan Administrator and the Claims Administrator do not decide what care you need or will receive. You and your Physician make those decisions;
- The Claims Administrator communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Services, which are more fully described in the Benefits Booklet); and
- The Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

The Plan Administrator and the Claims Administrator may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. The Plan Administrator and the Claims Administrator will use individually identifiable information about you as permitted or required by law, including in operations and in research. The Plan Administrator and the Claims Administrator will use de-identified data for commercial purposes including research.

The Plan is not intended to benefit any person other than Covered Persons. Other than direct payment to health care providers, a Covered Person cannot assign or alienate (voluntarily or involuntarily) the Covered Person's rights under or interest in the Plan, and any such attempt to

assign or alienate these rights or interests is void. In no event shall any assignment of benefits be construed to confer status as a participant in the Plan, or to confer standing to sue whether in a direct or representative capacity.

Relationship with Providers

The relationships between the Plan Administrator, the Claims Administrator and In-Network Providers are solely contractual relationships between independent contractors. In-Network Providers are not the Plan Administrator's agents or employees, nor are they agents or employees of the Claims Administrator. Neither the Plan Administrator nor any of its employees are agents or employees of In-Network Providers, nor are the Claims Administrator or any of its employee's agents or employees of In-Network Providers.

The Plan Administrator and the Claims Administrator do not provide health care services or supplies, nor do they practice medicine. Instead, the Plan Administrator and the Claims Administrator arrange for health care providers to participate in a network and pay benefits. In-Network Providers are independent practitioners who run their own offices and facilities. The Claims Administrator's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not the Plan Administrator's employees nor are they employees of the Claims Administrator. The Plan Administrator and the Claims Administrator do not have any other relationship with In-Network Providers such as principal-agent or joint venture. The Plan Administrator and the Claims Administrator are not liable for any act or omission of any provider.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. This means that you:

- Are responsible for choosing your own provider;
- Are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Coinsurance, any Deductible and any amount that exceeds eligible expenses;
- Are responsible for paying, directly to your provider, the cost of any non-Covered Service;
- Must decide if any provider treating you is right for you (this includes In-Network Providers you choose and providers to whom you have been referred); and
- Must decide with your provider what care you should receive.

Interpretation of Benefits

The Plan Administrator and the Claims Administrator have the sole and exclusive discretion to:

- Interpret benefits under the Plan
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD, the applicable Benefit Booklet and/or any Endorsements or amendments
- Make factual determinations related to the Plan and its Benefits.

The Plan Administrator and the Claims Administrator may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

Benefits under the Plan will be paid only if the Plan Administrator or Claims Administrator, as applicable, determines in its discretion that the claimant is entitled to them. Subject to applicable law, any interpretation of the provisions of the Plan and any decisions on any matter within the discretion of the Plan Administrator or Claims Administrator made in good faith shall be binding on all persons.

Information and Records

The Plan Administrator and the Claims Administrator may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. The Plan Administrator and the Claims Administrator may request additional information from you to decide your claim for benefits. The Plan Administrator and the Claims Administrator will keep this information confidential. The Plan Administrator and the Claims Administrator may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish the Plan Administrator and the Claims Administrator with all information or copies of records relating to the services provided to you. The Plan Administrator and the Claims Administrator have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled dependents whether or not they have signed the employee's enrollment form. The Plan Administrator and the Claims Administrator agree that such information and records will be considered confidential.

The Plan Administrator and the Claims Administrator have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as the Plan Administrator is required to do by law or regulation. During and after the term of the Plan, the Plan Administrator and the Claims Administrator and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements the Plan Administrator recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from the Claims Administrator, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, the Plan Administrator and the Claims Administrator will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. The Claims Administrator’s designees have the same rights to this information as does the Plan Administrator.

Workers' Compensation Not Affected
Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Future of the Plan
Although the Plan Sponsor expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Plan Sponsor's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Plan Sponsor does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits. If this Plan is terminated, Covered Persons will not have the right to any other benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Plan Sponsor decisions. After all benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Plan Sponsor and others as may be required by any applicable law.

SECTION 9 - IMPORTANT ADMINISTRATIVE INFORMATION

This section includes information on the administration of the Plan. While you may not need this information for your day-to-day participation, it is information you may find important.

Plan Sponsor and Administrator
The City of Jacksonville is the Plan Sponsor and Plan Administrator. The Plan Administrator has the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:

Plan Administrator – Medical Plan
The City of Jacksonville
City Hall, Suite 150
117 West Duval Street
Jacksonville, Florida 32202

Claims Administrator
Florida Blue is the Plan's Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative agreement with the City. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

You may contact the Claims Administrator by phone at the number on your ID card or in writing at:

Florida Blue
P.O. Box 1798
Jacksonville, FL 32231

Agent for Service of Legal Process
Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent of Service is the Plan Administrator:

The City of Jacksonville
City Hall, Suite 150
117 West Duval Street
Jacksonville, Florida 32202

Other Administrative Information
This section of your SPD contains information about how the Plan is administered.

Type of Administration
The Plan is a self-funded welfare Plan and the administration is provided through one or more third party administrators.

Plan Name:	The City of Jacksonville Employee Health and Welfare Plan
Plan Number:	B3267
Employer ID:	59-6000344
Plan Type:	Health and Welfare benefits plan
Plan Year:	January 1 – December 31
Plan Administration:	Self-Funded
Source of Plan Contributions:	Employee and the Employer
Source of Benefits:	Assets of the Employer

As a participant in the Plan, you are permitted to:

- Receive information about Plan benefits
- Examine, without charge, at the Plan Administrator's office and at other specified worksites, all plan documents – including pertinent insurance contracts, collective bargaining agreements (if applicable)
- Obtain copies of all Plan documents and other Plan information, including insurance contracts and collective bargaining agreements (if applicable), and updated Summary Plan Descriptions, by accessing the City's Compensation and Benefits website at http://www.coj.net/Benefits. You may also obtain copies from Employee Benefits.

You can 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 Plan documents to understand the rules governing your COBRA continuation coverage rights.

If you have any questions about your Plan, you should contact the Plan Administrator.

The Plan's benefits are administered by the Plan Administrator. Florida Blue is the Claims Administrator and processes claims for the Plan and provides appeal services; however, the Claims Administrator, the City and the Plan Administrator are not responsible for any decision you or your Dependents make to receive treatment, services or supplies, whether provided by an In-Network or Out-of-Network provider. The Claims Administrator, the City and the Plan Administrator are neither liable nor responsible for the treatment, services or supplies provided by In-Network or Out-of-Network providers.

ATTACHMENT I - HEALTH CARE REFORM

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.

Status Under Health Care Reform Law

Your Plan is not considered grandfathered for purposes of the Affordable Care Act. Consequently, the Plan must provide for the following to comply with the Affordable Care Act:

- **The elimination of any overall *lifetime* maximum** on the dollar value of essential health benefits that may have previously applied.
- **The elimination of any overall *annual* maximum** on the dollar value of essential health benefits that may have previously applied.
  NOTE: Lifetime or annual maximums may continue to apply to specific services if they are not considered essential health benefits. For guidelines on which services are considered "essential health benefits" contact Human Resources.
- **Coverage for adult dependents until 26,** regardless of whether the dependent is unmarried, married or is a student. The provision of the law does not require coverage for children of Covered Dependents. Florida law provides additional coverage for adult dependents (from the age of 26 through the end of the year in which they turn 30), who meet certain eligibility criteria as set forth in this SPD.
- **Coverage for preventive benefits with no member cost-sharing.** When preventive services are received from a network or participating provider, program deductibles, copayments or coinsurance will no longer apply. For a service such as a colonoscopy, related services such as operating room and anesthesia charges will also be covered at no cost to the member. For guidelines on which preventive services are affected, please consult http://www.heathcare.gov/ and search under Preventive Care.
- **Revisions to the appeals process.** An updated appeal process that complies with the new health care reform regulations now applies. For example, if an appeal is

denied internally, covered employees will now be able to request a further review by an independent external review entity.

Discrimination is Against the Law

The City of Jacksonville Employee Health and Welfare Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The City of Jacksonville Employee Health and Welfare Plan:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

• Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Kevin McDaniel, Chief, ADA Coordinator, Disabled Services Division, City of Jacksonville, telephone: (904) 255-5675; email: klmcdan@coj.net; or online at www.jaxada.com.

If you believe that the City of Jacksonville Employee Health and Welfare Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Kevin McDaniel, Chief/ADA Coordinator, Disabled Services Division, City of Jacksonville, 117 West Duval Street, Suite 205, Jacksonville, FL 32202; telephone number: (904) 255-5675 (TTY number: (904) 255-5475); fax: (904) 255-5474; email: klmcdan@coj.net; or online at www.jaxada.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Kevin McDaniel, Chief/ADA Coordinator, Disabled Services Division, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTACHMENT II - LEGAL NOTICES

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, the Plan provides benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving benefits in connection with a mastectomy, Benefits are also provided for the following Covered Services, as you determine appropriate with your attending Physician:

- 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 amount you must pay for such Covered Services (including Copayments and any Deductible) are the same as are required for any other Covered Service. Limitations on benefits are the same as for any other Covered Service.

Michelle's Law

Michelle's Law applies to group health plans for plan years beginning on or after October 9, 2009 (for calendar year plans, the law was effective beginning January 1, 2010). Michelle's Law provides continued coverage under group health plans for dependent children who are covered under the group health plan as a student but lose their student status because they take a medically necessary leave of absence.

As a result, if your child is no longer a student, as defined in the Plan, because he/she is on a medically necessary leave of absence, your child may continue to be covered under the Plan for up to one year from the beginning of the leave of absence. This continued coverage applies if, immediately before the first day of the leave of absence, your child was (1) covered under the Plan and (2) enrolled as a student at a post-secondary educational institution (includes colleges and universities).

For purposes of this continued coverage, a "medically necessary leave of absence" means a leave of absence from a post-secondary educational institution, or any change in enrollment of the child at the institution, that:

- begins while the child is suffering from a serious illness or injury,
- is medically necessary, and
- causes the child to lose student status for purposes of coverage under the plan.

The coverage provided to dependent children during any period of continued coverage:

- is available for up to one year after the first day of the medically necessary leave of absence, but ends earlier if coverage under the Plan would otherwise terminate, and
- stays the same as if your child had continued to be a covered student and had not taken a medically necessary leave of absence.

If the coverage provided by the Plan is changed during this one-year period, the Plan must provide the changed coverage for the dependent child for the remainder of the medically necessary leave of absence unless, as a result of the change, the Plan no longer provides coverage for dependent children.

If you believe your child is eligible for this continued coverage, the child's treating physician must provide a written certification to the Plan stating that your child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

Coordination with COBRA Continuation Coverage – If your child is eligible for Michelle's Law's continued coverage and loses coverage under the Plan at the end of the continued coverage period, continuation coverage under COBRA will be available at the end of Michelle's Law's coverage period and a COBRA notice will be provided at that time.

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of any individual or family member of the individual, except as specifically allowed by this law. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Mental Health Parity and Addiction Equity Act

Notwithstanding anything in the Plan to the contrary, to the extent required by law, the Plan will comply with the Mental Health Parity and Addiction Equity Act ("MHPAEA"), including, but not limited to, not imposing any lifetime or annual limits on mental health benefits that violate the applicable requirements of MHPAEA. This law precludes group health plans from imposing financial requirements and treatment limitations on mental health or substance abuse benefits that are more restrictive than financial requirements and treatment limitations on medical and surgical benefits. MHPAEA also may prevent the Plan from placing annual or lifetime dollar limits on mental health and substance abuse benefits that are less favorable than annual or lifetime dollar limits for medical and surgical benefits offered under the plan.

Although the law requires "parity", or equivalence, with regard to annual and lifetime dollar limits, financial requirements and treatment limitations, MHPAEA does not require group health plans and their health insurance issuers to include these benefits in their medical plan.

Key changes made by MHPAEA include the following:

- If a group health plan includes medical and surgical benefits and mental health and substance abuse benefits, the financial requirements (e.g., deductibles and co-payments) and treatment limitations (e.g., number of visits or days of coverage) that apply to mental health and substance abuse benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical and surgical benefits;
- Mental health and substance abuse benefits may not be subject to any separate cost sharing requirements or treatment limitations that only apply to such benefits;
- If a group health plan includes medical and surgical benefits and mental health and substance abuse benefits, and the plan provides for out of network medical and surgical benefits, it must provide for out of network mental health and substance abuse benefits; and
- Standards for medical necessity determinations and reasons for any denial of benefits relating to mental health and substance abuse benefits must be disclosed upon request.

Prescription Drug Coverage and Medicare

This notice has information about your current prescription drug coverage with the City and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The City has determined that the prescription drug coverage offered by the Plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15th through December 7th. Beneficiaries leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

If you decide to enroll in a Medicare prescription drug plan, you may keep your current prescription drug coverage or you may choose to drop it. Prescription drug coverage is automatically included as part of your overall coverage under the Plan. In order to drop your prescription drug coverage, you would therefore have to drop your coverage under the entire medical plan. If you do choose to

drop your coverage under the Plan (including your prescription drug coverage), be aware that you will not be able to get this coverage back.

You should compare your current prescription drug coverage, including which drugs are covered, with the coverage and cost of Medicare prescription drug plans in your area.

If you drop or lose your coverage under the Plan (including your prescription drug coverage) and do not enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later. If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19% higher than what most other people pay.

You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until the next October 15th to enroll.

For more information about this notice or your current prescription drug coverage contact Employee Benefits. You may receive this notice at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through City changes. You also may request a copy from Employee Benefits at any time.

For more information about your options under Medicare prescription drug coverage: More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. Every year, you should receive a copy of the handbook in the mail from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can get more information about Medicare prescription drug plans by:

- Visiting www.medicare.gov for personalized help,
- Calling your State Health Insurance Assistance Program (see your copy of the "Medicare & You" handbook for telephone numbers), or
- Calling 1-800-MEDICARE (1-800-633-4227); TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call 1-800-772-1213 (TTY 1-800-325-0778).

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay

for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify the Claims Administrator. For information on notification or prior authorization, contact the Claims Administrator.

ATTACHMENT III – Rules Regarding Use and Disclosure of Protected Health Information

Use and Disclosure of Protected Health Information

The Plan will use or disclose "Protected Health Information" (PHI) to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the regulations issued thereunder, as amended from time to time, including 45 CFR Parts 160 and 164, subparts A, D and E (HIPAA Privacy Rule) and 45 CFR Parts 160 and 164, subpart C (HIPAA Security Rule).

Use and Disclosure of PHI as Permitted by Authorization of the Participant or Beneficiary

As soon as practicable following the receipt of an authorization from a participant or his or her duly appointed personal representative, the Plan will disclose PHI in accordance with the authorization.

Disclosure to the City

Upon request of the City, the Plan will disclose summary health information and enrollment and disenrollment information to the City as permitted pursuant to Section 164.504 of the HIPAA Privacy Rule.

The Plan will disclose PHI other than summary health information and enrollment and disenrollment information for purposes related to "plan administration," "treatment," "payment" and "health care operations" as described above to the City only upon receipt of a certification from the City that the applicable Plan documents have been amended to incorporate the provisions set forth in the remaining sections of this Appendix.

To receive PHI as described in the preceding paragraph, the City shall certify to the Plan that it agrees to:

- not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
- implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that the City creates, receives, maintains, or transmits on behalf of the Plan;
- ensure that any agents, including a subcontractor, to whom the City provides PHI received from the Plan agree to the same restrictions and conditions that apply to the City with respect to such PHI;
- not use or disclose PHI for employment-related actions and decisions unless authorized by the individual that is the subject of the PHI or his or her duly appointed personal representative;
- not use or disclose PHI in connection with any other benefit or employee benefit plan of the City unless authorized by an individual;

- report to the Plan (i) any security incident as defined under the HIPAA Security Rule, and (ii) any Breach of Unsecured Protected Health Information; provided, however, that to avoid unnecessary burden on either party, the City shall report to the Plan any unsuccessful security incidents of which it becomes aware of only upon request of the Plan. The frequency, content and the format of the report of unsuccessful security incidents shall be mutually agreed upon by the parties. The term "unsuccessful security incidents" mean security incidents that do not result in unauthorized access, use, disclosure, modification or destruction of electronic PHI;

- make PHI available to an individual in accordance with HIPAA's access requirements;

- make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

- make available the information required to provide an accounting of disclosures;

- make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and

- if feasible, return or destroy all PHI received from the Plan that the City still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which the disclosure was made. Where the return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction not feasible.

Adequate Separation Between the Plan and the City Must Be Maintained

In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

- Privacy Officer.

- Designee(s) of the Privacy Officer.

- Designated members of the Employee Benefits, Payroll and Accounting Divisions.

- Designated members of the Information Technology Division.

The persons described in this section may only have access to and use and disclose PHI for the purposes described above.

If the persons described in this section do not comply with this plan document, the City shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.