THE CAFETERIA PLAN

SUMMARY PLAN DESCRIPTION

FOR

CITY OF JACKSONVILLE

Introduction

CITY OF JACKSONVILLE (the "Employer") sponsors the CITY OF JACKSONVILLE Cafeteria Plan (the "Cafeteria Plan") that allows eligible Employees to choose from a menu of different benefits paid for with pre-tax dollars. (Such plans are also commonly known as "salary reduction plans" or "Section 125 plans").

This Summary Plan Description ("Summary") describes the basic features of the Cafeteria Plan, how it generally operates and how Employees can gain the maximum advantage from it.

PLEASE NOTE: This Summary is for general informational purposes only. It does not describe every detail of the Cafeteria Plan. If there is a conflict between the Cafeteria Plan documents and this Summary, then the Cafeteria Plan documents will control.

Cafeteria Plan

CAF Q-1. How do I pay for CITY OF JACKSONVILLE Cafeteria Plan benefits on a pre-tax basis?

You may elect to pay for benefits on a pre-tax basis by entering an election with the

Employer. At the Employer's option, this may be done with a traditional "paper" salary reduction agreement or it may be done in electronic form. Whatever medium is used, it shall be referred to as a Salary Reduction Agreement for purposes of this Summary.

If you elect to pay for benefits on a "pre-tax" basis, you agree to a salary reduction to pay for your share of the cost of coverage with pretax funds instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes.

Example CAF Q-1(a): Sally is paid an annual salary of $30,000. Sally's share of the costs for her elected benefits for the Plan Year totals $2,000, which will be deducted on a "pre-tax" basis. By doing so, she is electing to reduce her salary, and therefore also her taxable income, by $2,000 for the year to $28,000.

From then on, you must pay contributions for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck, or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).

Example CAF Q-1(b): Using the same facts from Example Q-1(a), suppose Sally is paid 26 times a year (bi-weekly). Because she has elected $2,000 in benefits, she will have $76.92 deducted from each paycheck for the year ($2,000 divided by 26 paychecks equals $76.92).

CAF Q-2. What benefits may be elected under the Cafeteria Plan?

The Cafeteria Plan includes the following benefit plans:

The Health Flexible Spending Arrangement ("**Health FSA**") permits an Employee to use "pre-tax" dollars to pay for his or her qualifying Medical Care Expenses (defined in HFSA Q-7) that are not otherwise reimbursed by insurance.

The **Dependent Care Assistance Program** ("**DCAP**") permits an Employee to pay for his or her qualifying Dependent Care Expenses (defined in **DCAP** Q-7) with pre-tax dollars.

If you select one or more of the above benefits, you will pay all or some of the contributions; the Employer may contribute some or no portion of them. The applicable amounts will be described in documents furnished separately to you as necessary from time to time.

CAF Q-3. Who can participate in the Cafeteria Plan?

Employees who are working 25 or more hours per week are eligible to participate in the Cafeteria Plan following 0 of employment with the Employer, provided that the election procedures in CAF Q-5 are followed.

An "Employee" is any individual who the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll. Employees do not, however, include the

following: any leased employee (including but not limited to those individuals defined as leased employees in Code § 414(n)) or an individual classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer; any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer; any self-employed individual; any partner in a partnership; and any more-than-2% shareholder in a Subchapter S corporation.

CAF Q-4. What tax savings are possible under the Cafeteria Plan?

You may save both federal income tax and FICA (Social Security/Medicare) taxes by participating in the CITY OF JACKSONVILLE Cafeteria Plan.

Example CAF Q4(a): Suppose Sally pays 15% in federal income taxes for the year. With an annual salary of $30,000, that could mean as much as $4,500 in federal income taxes, plus $2,295 in FICA taxes (calculated at 7.65% of income). But by electing $2,000 of cafeteria plan benefits for the year, Sally lowers her taxable income by $2,000, meaning she is only taxed on $28,000. This comes out to $4,200 in income tax plus $2,142 in FICA tax. That's a $453 tax savings for the year.

(**Caution**: This example is intended to illustrate the general effect of "pre-taxing" benefits through a cafeteria plan. It does not take into account the effects of filing status, tax exemptions, tax deductions and other factors affecting tax liability. Furthermore, the amount of the contributions used in this example is not meant to reflect your actual contributions. It is also not intended to reflect specifically upon your particular tax situation. You are encouraged to consult with your accountant or other professional tax advisor with regard to your particular tax situation.)

CAF Q-5. When does participation begin and end in the Cafeteria Plan?

After you satisfy the eligibility requirements, you may enter the Plan first of the month following the date of hire. You can become a Participant by electing benefits in a manner such as described in CAF Q-1. An eligible Employee who does not elect benefits will not be able to elect any benefits under the Cafeteria Plan until the next Open Enrollment Period (unless a "Change in Election Event" occurs, as explained in CAF Q-7).

An Employee continues to participate in the Cafeteria Plan until (a) termination of the Cafeteria Plan; or (b) the date on which the Employee ceases (because of retirement, termination of employment, layoff, reduction of hours, or any other reason) to be an Eligible Employee. Notwithstanding the foregoing, for purposes of pre-taxing COBRA coverage certain Employees may continue eligibility for certain periods on the terms and subject to

the restrictions described in Section 6.4 for Insurance Benefits and Section 7.8 for Health FSA Benefits.However, for purposes of pre-taxing COBRA coverage for Health FSA Benefits, certain Employees may be able to continue eligibility in the Cafeteria Plan for certain periods. See CAF Q-8 and CAF Q-12 for more information about this as information about how termination of participation affects your Benefits.

CAF Q-6. What is meant by "Open Enrollment Period" and "Plan Year"?

The "Open Enrollment Period" is the period during which you have an opportunity to participate under the Cafeteria Plan by electing to do so. (See Q-5.) You will be notified of the timing and duration of the Open Enrollment Period, which for any new Plan Year generally will occur during the quarter preceding the new Plan Year.

The Plan Year for the CITY OF JACKSONVILLE Cafeteria Plan is the 12 months beginning on January 1 and ending on December 31.

CAF Q-7. Can I change my elections under the Cafeteria Plan during the Plan Year?

With the exception of HSA benefits (for which prospective election changes generally are allowable), you generally cannot change your election to participate in the Cafeteria Plan or vary the salary reduction amounts that you have selected during the Plan Year (this is known as the "irrevocability rule"). Of course, you can change your elections for benefits and salary reductions during the Open Enrollment Period, but those election changes will apply only for the following Plan Year.

However, there are several important exceptions to the irrevocability rule, many of which have to do with events in your personal or professional life that may occur during the Plan Year. Be advised, however, that there are very few exceptions applicable to Health FSAs.

Here are the exceptions to the irrevocability rule:

1. Leaves of Absence

(Applies to Health FSA and DCAP Benefits.)

You may change an election under the Cafeteria Plan upon FMLA and non-FMLA leave only as described in CAF Q-14.

2. Change in Status.

(Applies to Health FSA Benefits as Limited Below and to DCAP Benefits.)

If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status (as described in item 3 below). Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Plan Administrator, in its sole discretion and on a uniform and

consistent basis, determines are permitted under IRS regulations:

• a change in your legal marital status (such as marriage, death of a Spouse, divorce, legal separation, or annulment);

• a change in the number of your Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent);

• any of the following events that change the employment status of you, your Spouse, or your Dependent and that affect benefits eligibility under a cafeteria plan (including this Cafeteria Plan) or other employee benefit plan of you, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite; switching from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa); incurring a reduction or increase in hours of employment; or any other similar change that makes the individual become (or cease to be) eligible for a particular employee benefit;

• an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as reaching age 26, ceasing to be a student, or a similar circumstance); or

3. Change in Status—Other Requirements.

(Applies to Health FSA Benefits as Limited Below and to DCAP Benefits.)

If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects coverage eligibility (for DCAP Benefits, the event may also affect eligibility of Dependent Care Expenses (as defined in DCAP Q-7) for the dependent care tax exclusion).

Election changes may be made to reduce Health FSA coverage during a Period of Coverage or to cancel Health FSA coverage completely due to the occurrence of any of the following events: death of your Spouse, divorce, legal separation, or annulment; death of your Dependent; change in employment status such that you become ineligible for Health FSA coverage; or your Dependent's ceasing to satisfy eligibility requirements for Health FSA coverage (e.g., on account of attaining a specific age).

In addition, you must satisfy the following specific requirements in order to alter your election based on that Change in Status:

• Loss of Spouse or Dependent Eligibility; Special COBRA Rules. For accident and health benefits (here, the Health FSA Benefits), a special rule governs which type of election changes are consistent with the Change in Status. For a Change in Status involving your divorce, annulment, or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent's ceasing to satisfy the eligibility requirements for coverage, you may elect only to cancel the accident or health benefits for the affected Spouse or Dependent. A change in election for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements would fail to correspond with that Change in Status.

However, if you, your Spouse, or your Dependent elects COBRA continuation coverage under the Employer's plan because you ceased to be eligible because of a reduction of hours or because your Dependent ceases to satisfy eligibility requirements for coverage, and if you remain a Participant under the terms of this Cafeteria Plan, then you may in certain circumstances be able to increase your contributions to pay for such coverage. See CAF Q-12.

• Gain of Coverage Eligibility Under Another Employer's Plan. For a Change in Status in which you, your Spouse, or your Dependent gains eligibility for coverage under another employer's cafeteria plan (or qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Cafeteria Plan would correspond with that Change in Status only if coverage for that individual becomes effective or is increased under the other employer's plan.

• DCAP Benefits. With respect to the DCAP Benefits, you may change or terminate your election with respect to a Change in Status event only if (a) such change or termination is made on account of and conforms with a Change in Status that affects eligibility for coverage under the DCAP; or (b) your election change is on account of and conforms with a Change in Status that affects the eligibility of Dependent Care Expenses for the available tax exclusion.

Example: Employee Mike is married to Sharon, and they have a 12-year-old daughter. The employer's plan offers a DCAP as part of its cafeteria plan. Mike elects to reduce his salary by $2,000 during a plan year to fund dependent care coverage for his daughter. In the middle of the plan year when the daughter turns 13 years old, however, she is no longer eligible to participate in the DCAP. This event constitutes a Change in Status. Mike's election to cancel coverage under the DCAP would be consistent with this Change in Status.

4. Special Enrollment Rights. (Does Not apply to Health FSA or DCAP.)

5. Certain Judgments, Decrees, and Orders. *(Applies to Health FSA Benefits, but Not to DCAP Benefits.)* If a judgment, decree, or order from a divorce, separation, annulment, or

custody change requires your child (including a foster child who is your Dependent) to be covered under the Health FSA Benefits, you may change your election to provide coverage for the child. If the order requires that another individual (such as your former Spouse) cover the child, then you may change your election to revoke coverage for the child, provided that such coverage is, in fact, provided for the child.

6. Medicare or Medicaid. *(Applies to Health FSA Benefits as Limited Below, but Not to DCAP Benefits.)* If you, your Spouse, or your Dependent becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid, then your Health FSA coverage may be canceled completely but not reduced. Similarly, if you, your Spouse, or your Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then you may elect to commence or increase that person's accident or health coverage (here, Health FSA Benefits, as applicable).

7. Change in Cost. *(Applies to DCAP Benefits as Limited Below, but Not to Health FSA Benefits.)* If the cost charged to you for your DCAP Benefits significantly increases during the Plan Year, then you may choose to do any of the following: (a) make a corresponding increase in your contributions; (b) revoke your election and receive coverage under another benefit package option (if any) that provides similar coverage, or elect similar coverage under the plan of your Spouse's employer; or (c) drop your coverage, but only if no other benefit package option provides similar coverage. If the cost of DCAP Benefits significantly decreases during the Plan Year, then the Plan Administrator may permit the following election changes: (a) if you are enrolled in the benefit package option that has decreased in cost, you may make a corresponding decrease in your contributions; (b) if you are otherwise eligible, you may elect the benefit package option that has decreased in cost on a prospective basis, subject to the terms and limitations of the benefit package option.

For insignificant increases or decreases in the cost of benefits, however, the Plan Administrator will automatically adjust your election contributions to reflect the minor change in cost.

You will have to notify the Plan Administrator of increases or decreases in the cost of DCAP benefits.

The change in cost provision applies to DCAP Benefits only if the cost change is imposed by a dependent care provider who is not your relative.

8. Change in Coverage. *(Applies to DCAP Benefits, but Not to Health FSA Benefits.)* You may also change your election if one of the following events occurs:

• Significant Curtailment of Coverage. If your DCAP Benefits coverage is significantly curtailed without a loss of coverage, then you may revoke your election for that coverage and elect coverage under another benefit package option that provides similar coverage. (Coverage under a plan is significantly curtailed only if there is an overall reduction of

coverage under the plan generally—loss of one particular physician in a network does not constitute significant curtailment.) If your DCAP Benefits coverage is significantly curtailed with a loss of coverage (for example, if you lose all coverage under the option by reason of an overall lifetime or annual limitation), then you may either revoke your election and elect coverage under another benefit package option that provides similar coverage, elect similar coverage under the plan of your Spouse's employer, or drop coverage, but only if there is no option available under the plan that provides similar coverage. (You will have to notify the Plan Administrator of significant curtailments in DCAP Benefits coverage.)

• Addition or Significant Improvement of Cafeteria Plan Option. If the Cafeteria Plan adds a new option or significantly improves an existing option, then the Plan Administrator may permit Participants who are enrolled in an option other than the new or improved option to elect the new or improved option. Also, the Plan Administrator may permit eligible Employees to elect the new or improved option on a prospective basis, subject to limitations imposed by the applicable option.

• Change in Election Under Another Employer Plan. You may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or a plan of your Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Cafeteria Plan permits you to make an election for a period of coverage (for example, the Plan Year) that is different from the period of coverage under the other cafeteria plan or qualified benefits plan, which it does.

For example, if an election to drop coverage is made by your Spouse during his or her employer's open enrollment, you may add coverage under the Cafeteria Plan to replace the dropped coverage.

• DCAP Coverage Changes. You may make a prospective election change that is on account of and corresponds with a change by your dependent care service provider. For example: (a) if you terminate one dependent care service provider and hire a new dependent care service provider, then you may change coverage to reflect the cost of the new service provider; and (b) if you terminate a dependent care service provider because a relative becomes available to take care of the child at no charge, then you may cancel coverage.

9. Change in HSA Elections. If you have enrolled in the Plan during Open Enrollment and have elected HSA Benefits, then you may increase, decrease, or revoke your HSA Benefits election on a prospective basis at any time during the Plan Year, in accordance with the Plan's administrative procedures for processing election changes. No other benefit package option election changes can be made as a result of a change in your HSA Benefits election unless permitted as a result of events otherwise described in this Attachment. For example, generally you would not be able to terminate an election under the Health FSA in order to

be eligible for the HSA, unless one of the exceptions described above for Health FSA Benefits otherwise applied (such as a change in status).

Participants can change their elections under the Cafeteria Plan during a Plan Year if an event occurs that is a Change in Election Event and certain other conditions are met, as described below. For details, see the various Change in Election Events headings below for the specific type of Change in Election Event:

Leaves of absence, including FMLA leave (defined in CAF Q-14); Changes in Status; Special Enrollment Rights;

Certain Judgments, Decrees, and Orders; Medicare or Medicaid; Changes in Cost; Changes in Coverage; and Changes in HSA Elections. Note that the Change in Election Events do not apply for all Benefits—applicable exclusions are described under the relevant headings. In addition, as explained hereafter in this CAF Q-7, the Plan Administrator can change certain elections on its own initiative. Note also that no changes can be made with respect to Medical Insurance Benefits if they are not permitted under the Medical Insurance Plan.

If any Change in Election Event occurs, you must inform the Plan Administrator and complete a new election (depending on your employer's enrollment process, this may be either via a paper or electronic Salary Reduction Agreement), within 30 days after the occurrence. If the change involves a loss of your Spouse's or Dependent's eligibility for Medical Insurance Benefits, then the change will be deemed effective as of the date that eligibility is lost due to the occurrence of the Change in Election Event, even if you do not request it within 30 days.

The Plan Administrator may also reduce your salary reductions (and increase your taxable regular pay) during the Plan Year if you are a key employee or highly compensated individual as defined by the Internal Revenue Code ("the Code"), if necessary to prevent the Cafeteria Plan from becoming discriminatory within the meaning of the federal income tax law. Additionally, if a mistake is made as to your eligibility or participation, the allocations made to your account, or the amount of benefits to be paid to you or another person, then the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under the Code and other applicable law, allocate, withhold, accelerate, or otherwise adjust such amounts as will in its judgment accord the credits to the account or distributions to which you are or such other person is properly entitled under the Cafeteria Plan. Such action by the Plan Administrator may include withholding of any amounts due from your compensation.

CAF Q-8. What happens if my employment ends during the Plan Year or I lose eligibility for other reasons?

If your employment with the Employer is terminated during the Plan Year, then your active participation in the Cafeteria Plan will cease and you will not be able to make any more

contributions to the Cafeteria Plan for Health FSA Benefits and DCAP Benefits.

See CAF Q-12 for information on your right to continued or converted group health coverage after termination of your employment.

For reimbursement of expenses from the Health FSA Account after termination of employment, see HFSA Q-9.

For reimbursement of expenses from the DCAP Account after termination of employment, see DCAP Q-9.

For purposes of pre-taxing COBRA coverage for , certain Employees may be able to continue eligibility in the Cafeteria Plan for certain periods. See CAF Q-12.

If you are rehired within the same Plan Year and are eligible for the Cafeteria Plan, then you may make new elections, provided that you are rehired more than 30 days after you terminated employment. If you are rehired within 30 days or less during the same Plan Year, then your prior elections will be reinstated.

If you cease to be an eligible Employee for reasons other than termination of employment, such as a reduction of hours, then you must complete the waiting period described in CAF Q-3 before again becoming eligible to participate in the Plan.

CAF Q-9. Will I pay any administrative costs under the Cafeteria Plan?

At the discretion of the employer, administrative costs may be borne by the Employer or the Employee. The Employer also reserves the right to offset these costs with available Cafeteria Plan forfeitures.

CAF Q-10. How long will the Cafeteria Plan remain in effect?

Although the Employer expects to maintain the Cafeteria Plan indefinitely, it has the right to amend or terminate all or any part of the Cafeteria Plan at any time for any reason. It is also possible that future changes in state or federal tax laws may require that the Cafeteria Plan be amended accordingly.

CAF Q-11. What happens if my claim for benefits is denied?

Claims Under the Cafeteria Plan, Health FSA or DCAP.

If a claim for reimbursement under the Health FSA or DCAP Components of the Cafeteria Plan is wholly or partially denied, or you are denied a benefit under the Cafeteria Plan due to an issue germane to your coverage under the Cafeteria Plan (for example, a determination of a Change in Status; a “significant” change in contributions charged; or eligibility and participation matters under the Cafeteria Plan document), then the claims procedure described below will apply:

If your claim is denied in whole or in part, you will be notified in writing by within 30 days after the date of the receipt of your claim. (This time period may be extended for an additional 15 days such as in cases where a claim is incomplete. You will be provided with written notice of any extension, including the reasons for the extension and the date by which a decision is expected to be made. Where a claim is incomplete, the extension notice will also specifically describe the required information, will allow you 45 days from receipt of the notice in which to provide the specified information and will have the effect of suspending the time for a decision on your claim until the specified information is provided.)

Notification of a denied claim will set out:

• a specific reason or reasons for the denial;

• the specific Plan provision on which the denial is based;

• a description of any additional material or information necessary for you to validate the claim and an explanation of why such material or information is necessary;

• appropriate information on the steps to be taken if you wish to appeal the Plan Administrator's decision, including your right to submit written comments and have them considered, your right to review (upon request and at no charge) relevant documents and other information, and your right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of your claim.

Appeals.

If your claim is denied in whole or part, then you (or your authorized representative) may request review upon written application to the "Committee" (the Benefits Committee that acts on behalf of the Plan Administrator with respect to appeals). Your appeal must be made in writing within 180 days after your receipt of the notice that the claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal.

Decision on Review.

Your appeal will be reviewed and decided by the Committee or other entity designated in the Plan in a reasonable time not later than 60 days after the Committee receives your request for review. The Committee may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of a medical expert consulted in connection with your appeal will be provided. If the

decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

• the specific reason(s) for the decision on review;

• the specific Plan provision(s) on which the decision is based;

• a statement of your right to review (upon request and at no charge) relevant documents and other information;

• if an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and

• a statement of your right to bring suit under ERISA § 502(a) (where applicable).

CAF Q-12. What is "Continuation Coverage" and how does it work?

COBRA.

For a discussion of your Continuation and Reinstatement rights please refer to Appendix A.

USERRA.

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). More information about coverage under USERRA is available from the Plan Administrator.

CAF Q-13. How will participating in the Cafeteria Plan affect my Social Security and other benefits?

Participating in the Cafeteria Plan will reduce the amount of your taxable income, which may result in a decrease in your Social Security benefits and/or other benefits which are based on taxable income. However, the tax savings that you realize through Cafeteria Plan participation will often more than offset any reduction in other benefits. If you are still unsure, you are encouraged to consult with your accountant or other tax advisor.

CAF Q-14. How do leaves of absence (such as under FMLA) affect my benefits?

FMLA Leaves of Absence.

NOTE: The following shall only apply if the Employer is subject to the federal Family and Medical Leave Act of 1993 (FMLA).

If you go on a qualifying leave under the federal Family and Medical Leave Act of 1993

(FMLA), then to the extent required by the FMLA your Employer will continue to maintain your Health FSA Benefitson the same terms and conditions as if you were still active (that is, your Employer will continue to pay its share of the contributions to the extent that you opt to continue coverage). Your Employer may require you to continue all Health FSA Benefits coverage while you are on paid leave (so long as Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, on a pre-tax salary-reduction basis).

If you are going on unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued) and you opt to continue your Health FSA benefits, then you may pay your share of the contributions in one of three ways: (a) with after-tax dollars while on leave; (b) with pretax dollars to the extent that you receive compensation during the leave, or by pre-paying all or a portion of your share of the contributions for the expected duration of the leave on a pre-tax salary reduction basis out of your pre-leave compensation, including unused sick days and, if applicable, vacation days (to pre-pay in advance, you must make a special election before such compensation normally would be available to you (but note that prepayments with pre-tax dollars may not be used to pay for coverage during the next Plan Year); or (c) by other arrangements agreed upon by you and the Plan Administrator (for example, the Plan Administrator may pay for coverage during the leave and withhold amounts from your compensation upon your return from leave).

If your Employer requires all Participants to continue Health FSA Benefits during the unpaid FMLA leave, then you may discontinue paying your share of the required contributions until you return from leave. Upon returning from leave, you must pay your share of any required contributions that you did not pay during the leave. Payment for your share will be withheld from your compensation either on a pre-tax or after-tax basis, depending on what you and the Plan Administrator agree to.

If your Health FSA Benefits coverage ceases while you are on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter such Benefits, as applicable, upon return from such leave on the same basis as when you were participating in the Plan before the leave or as otherwise required by the FMLA. You may be required to have coverage for such Benefits reinstated so long as coverage for Employees on non-FMLA leave is required to be reinstated upon return from leave. But despite the preceding sentence, with regard to Health FSA Benefits, if your coverage ceased you will be permitted to elect whether to be reinstated in the Health FSA Benefit at the same coverage level as was in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro rata for the period of FMLA leave during which you did not pay contributions. If you elect the pro rata coverage, the amount withheld from your compensation on a payroll-by-payroll basis for the purpose of paying for reinstated Health FSA Benefits will equal the amount withheld before FMLA leave.

If you are commencing or returning from FMLA leave, then your election for non-health benefits (such as DCAP Benefits) will be treated in the same way as under your Employer's policy for providing such Benefits for Participants on a non-FMLA leave (see below). If that policy permits you to discontinue contributions while on leave, then upon returning from leave you will be required to repay the contributions not paid by you during leave. Payment will be withheld from your compensation either on a pre-tax or after-tax basis, as agreed to by the Plan Administrator and you or as the Plan Administrator otherwise deems appropriate.

If your Employer conducts an open enrollment during the time which you are on an FMLA leave, you will be eligible to participate in the open enrollment.

Non-FMLA Leaves of Absence.

If you go on an unpaid leave of absence that does not affect eligibility, then you will continue to participate and the contribution due from you (if not otherwise paid by your regular salary reductions) will be paid by pre-payment before going on leave, with after-tax contributions while on leave, or with catch-up contributions after the leave ends, as determined by the Plan Administrator. If you go on an unpaid leave that does affect eligibility, then the Change in Status rules will apply (see the attachment entitled "When Can I Change Elections Under the Cafeteria Plan During the Plan Year?" found at the end of this Summary).

If your Employer conducts an open enrollment during the time which you are on a non-FMLA leave, you will be eligible to participate in the open enrollment.

CAF Q-15. Who is a "Spouse" under the Plan?

A "spouse" is any individual treated as a spouse for federal tax purposes, including but not limited to same-sex spouses legally married in a state recognizing same-sex marriages, regardless of the Participant's or the Spouse's current state of residence.

Health FSA Benefits

HFSA Q-1. What are "Health FSA Benefits"?

As described in Q-2, a Health FSA permits eligible Employees to pay Medical Care Expenses not reimbursed elsewhere (for example, you cannot be reimbursed for the same expense from an insurance plan.

As described in Q-1, if you elect Health FSA Benefits, then you will be able to provide a source of pre-tax funds to reimburse yourself for your eligible Medical Care Expenses by

entering into a Salary Reduction Agreement with your Employer.

The Health FSA shall not be considered to be a group health plan for coordination of benefits purposes, and Health FSA Benefits shall not be taken into account when determining benefits payable under any other plan.

In the event that an expense is eligible for reimbursement under both the Health FSA and the HSA, you may seek reimbursement from either the Health FSA or the HSA, but not both.

A general-purpose health FSA constitutes family coverage because it is available to pay or reimburse the qualified medical expenses of the employee and the employee's spouse and dependents. Consequently, if either spouse participates in a general-purpose health FSA, neither spouse will be eligible to contribute to an HSA either through the spouse's employer or individually through a bank. Likewise, the fact that an adult child's qualified medical expenses could be reimbursed by a parent's general-purpose health FSA (i.e., because the child is under age 27 as of the end of the taxable year) will prevent the adult child from being HSA-eligible.

HFSA Q-2. Can I participate in the Health FSA Benefit?

Eligibility requirements for the Health FSA Benefit are the same as the eligibility requirements described under CAF Q-3. After you satisfy the eligibility requirements, you may participate in the Health FSA by enrolling in the plan, as described under CAF Q-5.

HFSA Q-3. What is my "Health FSA Account"?

If you elect Health FSA Benefits, then an account called a "Health FSA Account" will be set up in your name to keep a record of the reimbursements that you are entitled to, as well as the contributions that you have paid for such benefits during the Plan Year. Your Health FSA Account is merely a recordkeeping account: it is not funded (that is, all reimbursements are paid from the general assets of the Employer), and it does not bear interest.

Subject to the Employer's benefit offering, a Health FSA election may be for:

(a) General-Purpose Health FSA Coverage;

(b) Limited (Vision/Dental/Preventive Care) Health FSA Coverage; or

(c) Employee-Only Health FSA Coverage; or

(d) Employee-Plus-Children Health FSA Coverage.

Note: If you elect Health FSA Benefits, you cannot also elect HSA Benefits or otherwise make contributions to an HSA unless you elect a Limited (Vision/Dental/Preventive Care) Health FSA Coverage Option which is only available if offered by the employer. If you are married and elect the General-Purpose Health FSA Coverage Option, your spouse will also be ineligible to make HSA contributions. In addition, because the Health FSA includes a grace

period, if you have an election for Health FSA Benefits (other than the Limited (Vision/Dental/Preventive Care) Health FSA Coverage Option) that is in effect on the last day of a Plan Year, you cannot elect HSA Benefits or otherwise make contributions to an HSA for any of the first three calendar months following the close of that Plan Year, unless the balance in your Health FSA Account is $0 as of the last day of that Plan Year. Unless you have elected Employee-Only or Employee-Plus-Children Health FSA Coverage, your spouse (if you are married) will also be unable to make HSA contributions during this period, unless the balance in your Health FSA Account is $0 as of the last day of that Plan Year. For this purpose, your Health FSA Account balance is determined on a cash basis—that is, without regard to any claims that have been incurred but have not yet been reimbursed (whether or not such claims have been submitted).

HFSA Q-4. What is the maximum limit for the Health FSA Benefits that I may elect?

You may elect up to $3,400.00 in Health FSA benefits for the Plan year, and a minimum amount of $5.00.

Because of limitations on Health FSAs imposed by the Patient Protection and Affordable Care Act, you will only be able to elect up to the annual limit imposed by your Employer as defined above in this Section and/or any increases to such limit in future years.

If a Participant enters the Health FSA mid-year, then your maximum reimbursement dollar limit will be prorated based on a percentage of the Plan Year remaining.

HFSA Q-5. How are my Health FSA Benefits paid for under the Cafeteria Plan?

When you complete a Salary Reduction Agreement during the benefit enrollment process, you will specify the amount of Health FSA Benefits that you wish to pay for with your salary reduction. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).

HFSA Q-6. What amounts will be available for Health FSA reimbursement at any particular time during the Plan Year?

The full amount of Health FSA coverage that you have elected will be available to reimburse you for qualifying expenses incurred during the Plan Year (reduced by prior reimbursements made during the same Plan Year), regardless of the amount that you have contributed when you submitted the claim (so long as you continue participation).

Example HFSA Q-6(a): Sally elected $2,000 of coverage and contributed $307.69 to her Health FSA Account over the first four pay periods of the Plan Year ($2,000 divided by 26 pay periods equals $76.92 per pay period; $76.92 multiplied by four pay periods equals $307.69), ending on February 23rd of the Plan Year. Sally has had no claims until February

25th, when she incurs $400 in expenses. The entire $400 is available for reimbursement to Sally even though she has contributed only $307.69 to her Health FSA Account to that point.

You may also be able to be reimbursed from unused amounts remaining in your Health FSA Account at the end of a Plan Year for Medical Care Expenses incurred during a "grace period" following the end of the Plan Year. (See HFSA Q-8.)

HFSA Q-7. What are "Medical Care Expenses" that may be reimbursed from the Health FSA?

The Employer offers the following Health FSA options:

• General-Purpose Health FSA Coverage;

• Limited (Vision/Dental/Preventive Care) Health FSA Coverage, if offered by the employer;

Each of these Health FSA coverage options is described in detail below. Note: You cannot elect HSA Benefits and Health FSA Benefits together unless you elect the Limited (Vision/Dental/Preventive Care) Health FSA Coverage Option. In addition, if you have an election for Health FSA Benefits (other than the Limited (Vision/Dental/Preventive Care) Health FSA Coverage Option) that is in effect on the last day of a Plan Year, you cannot elect HSA Benefits for any of the first three calendar months following the close of that Plan Year, unless the balance in your Health FSA Account is $0 as of the last day of that Plan Year. For this purpose, your Health FSA Account balance is determined on a cash basis—that is, without regard to any claims that have been incurred but have not yet been reimbursed (whether or not such claims have been submitted).

The eligible "Medical Care Expenses" vary according to the type of Health FSA coverage option that is elected, as described below.

(a) *General-Purpose Health FSA Coverage Option.* For purposes of the General-Purpose Health FSA Coverage Option, "Medical Care Expense" means expenses incurred by you, your Spouse, or your Dependents for "medical care" as defined in Code § 213(d). Under the tax laws, "Medical Care Expenses" include expenses for OTC drugs and medicines as well as expenses for prescription drugs and menstrual products. However, as described above, only reasonable quantities of over-the-counter (OTC) drugs will be reimbursed from your Health FSA account in a single calendar month.

Ask the Plan Administrator if you need further information about which expenses are—and are not— likely to be reimbursable, but remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor. Since you derive tax benefits from this plan, you have responsibility for your compliance with tax laws.

(b) *Limited (Vision/Dental/Preventive Care) Health FSA Coverage Option.*

According to rules set forth in Code § 223 (applicable to HSAs), you will not be able to make/receive tax-favored contributions to your HSA if you participate in a Health FSA that reimburses medical expenses as defined for a General-Purpose Health FSA in subsection (a) above. You may, however, be eligible to make/receive tax-favored contributions to an HSA and participate in a Health FSA if the Health FSA reimbursement is limited to the following unreimbursed Code § 213(d) expenses:

• Services or treatments for dental care (excluding premiums);

• Services or treatments for vision care (excluding premiums); or

•Services or treatments for "preventive care." Preventive care is defined in accordance with applicable rules and regulations under Code § 223(c)(2)(C). (This may include any prescription drugs to the extent that such drugs are taken by an eligible individual (1) to delay or prevent the onset of symptoms of a condition for which symptoms have not yet manifested themselves (i.e., the eligible individual is asymptomatic); (2) to prevent the recurrence of a condition from which the eligible individual has recovered; or (3) as part of a preventive care treatment program (e.g., a smoking cessation or weight-loss program). Preventive care does not include services or treatments that treat an existing condition.

Orthodontia Expenses. Orthodontia expenses will be reimbursed "as incurred and paid". See below example:

Example: As Incurred and Paid (i.e., month by month) Rachel participates in a calendar-year Health FSA in 2024. In October 2024, she signs an agreement with an orthodontist to work on her son Ethan's teeth. During the first visit (November), Ethan is X-rayed and fitted for braces. During the second visit (December), the braces are installed. During 15 more monthly visits, the braces will be adjusted. Eventually (in 18 months, if everything goes as planned), the braces will be removed. For these services, the orthodontist charges $5000. Rachel is required to pay a $2000 down payment and $200 for each month thereafter. Under the incurred and paid option, Rachel can be reimbursed the $2000 in 2024, $2400 in 2025 (12 X $200) and $600 in 2026 (3 X $200).

PLEASE NOTE: "Down" payments for orthodontia are immediately reimbursable.

HFSA Q-8. When must the Medical Care Expenses be incurred for the Health FSA?

For expenses to be reimbursed to you from your Health FSA Account for the Plan Year, they must have been incurred during that Plan Year. The Plan Year for the Health FSA is the same as the Plan Year for the Cafeteria Plan—it is the 12-month period beginning on January 1 and ending on December 31. In addition, as discussed below, you may be able to be reimbursed from unused amounts remaining in your Health FSA Account at the end of a Plan Year for Medical Care Expenses incurred during a "grace period" following the end of

the Plan Year.

Grace periods will begin on January 1 and will end two months and 15 days later. Accordingly, the first grace period will be March 15, 2028 through March 15, 2028 and will apply to unused Health FSA amounts remaining at the end of the December 31 Plan Year.

A Medical Care Expense is incurred when the service that causes the expense is provided, not when the expense was paid. If you have paid for the expense but the services have not yet been rendered, then the expense has not been incurred. For example, if you prepay on the first day of the month for medical care that will be given during the rest of the month, the expense is not incurred until the end of that month (and cannot be reimbursed until after the end of that month). You may not be reimbursed for any expenses arising before the Health FSA or the Cafeteria Plan became effective, before your Salary Reduction Agreement became effective, for any expense incurred after the close of the Plan Year(except for certain expenses incurred during a grace period, as discussed below), or after a separation from service (except for Continuation Coverage, as described in CAF Q-12).

In order to take advantage of the grace period, you must be:

• a Participant in the Plan with Health FSA coverage that is in effect on the last day of the Plan Year to which the grace period relates (December 31); or

• a qualified beneficiary who has COBRA coverage under the Health FSA on the last day of the Plan Year to which the grace period relates (December 31).

See HFSA Q-9 regarding certain rules that apply to claims for reimbursement for Medical Care Expenses that are incurred during a grace period.

HFSA Q-9. What must I do to be reimbursed for Medical Care Expenses from the Health FSA?

In cases where you do not use an electronic payment card or “debit” card to pay for your incurred expenses, you must submit a Health FSA Reimbursement Request Form that will be supplied to you. You must include written statements and/or bills from independent third parties stating that the Medical Care Expenses have been incurred and stating the amount of such Medical Care Expenses, along with the Health FSA Reimbursement Request Form. Further details about what must be provided are contained in the Health FSA Reimbursement Request Form.

You will be reimbursed for your eligible Medical Care Expenses within 30 days after the date you submitted the Health FSA Reimbursement Request Form (subject to a 15-day extension in certain instances—see CAF Q-11 for more information). Claims will be paid in the order in which they are approved. Remember, though, that you can’t be reimbursed for any total expenses above the annual reimbursement amount that you have elected.

You will have 3 month(s) after the end of the Plan Year in which to submit a claim for reimbursement for Medical Care Expenses incurred during the previous Plan Year. However, if you have ceased to be eligible as a Participant, you will only have until 1 month(s) after the date you ceased to be eligible in which to submit claims for reimbursement for Medical Care Expenses incurred prior to the date on which you ceased to be eligible(or during any applicable grace period). You will be notified in writing if any claim for benefits is denied. (See CAF Q-11 for more information.)

The following additional rules will apply to Medical Care Expenses that are incurred during a grace period or are submitted after the close of the Plan Year in which they were incurred:

• Medical Care Expenses incurred during a grace period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the preceding Plan Year and then from any amounts that are available to reimburse expenses incurred during the current Plan Year. For example, assume that $300 remains in your Health FSA Account at the end of the 2024 Plan Year and that you have also elected $3000 of Health FSA coverage for 2025. If you submit a $700 Medical Care Expense that was incurred on January 15, 2025, $300 of your claim will be paid out of the unused amounts remaining in your Health FSA Account from the 2024 Plan Year and the remaining $400 will be paid out of the amounts that are available to reimburse you for Medical Care Expenses incurred in the 2025 Plan Year.

• Once paid, a claim will not be reprocessed or otherwise re-characterized so as to change the Plan Year from which funds are taken to pay it. For example, using the same facts as in the example in the preceding paragraph, assume that a few days after being reimbursed for the $700 grace period expense, you discover $400 of 2024 Medical Care Expenses that have not been submitted for reimbursement. You cannot be reimbursed for the newly discovered expenses because no amounts remain to reimburse you for 2024 expenses. The Plan will not reprocess the $500 grace period expense so as to pay it entirely from your 2025 Health FSA amounts. For this reason, if you also have health FSA coverage for the current year, you may want to wait to submit Medical Care Expenses you incur during the grace period until you are sure you have no remaining unreimbursed expenses from the prior Plan Year.

• Expenses incurred during a grace period must be submitted within 3 month(s) after the close of the Plan Year to which the grace period relates in order to be reimbursed from amounts remaining at the end of that Plan Year. (As discussed above, this is also the deadline for submitting any claims for reimbursement of Medical Care Expenses incurred during the preceding Plan Year.)

To have your claims processed as soon as possible, please follow the instructions in CAF Q-11. Note that it is not necessary for you to have actually paid the amount due for a Medical Care Expense—only for you to have incurred the expense (as defined in HFSA Q-8) and that it is not being paid for or reimbursed from any other source.

HFSA Q-10 Do I still have to submit claims if I use a debit card?

If the Employer implements an electronic payment card program (such as a debit card to pay expenses from the Health FSA, some expenses may be validated at the time the expense is incurred (like co-pays for medical care). For other expenses, the card payment is only conditional and you will still have to submit supporting documents. In addition, expenses incurred during a grace period may need to be submitted manually in order to be reimbursed from unused amounts in your Health FSA Account from the preceding Plan Year if the card is unavailable for such reimbursement. You will receive more information from the Employer about what you must do to obtain reimbursement if such a system is implemented.

HFSA Q-11. Is there any risk of losing or forfeiting the amounts that I elect for Health FSA Benefits?

Yes. If the Medical Care Expenses that you incur during the Plan Year or during the grace period immediately following the Plan Year (if you are eligible for the grace period—see HFSA Q-8) are less than the annual amount that you elected for Health FSA Benefits, you will forfeit the rest of that amount—this is called the "use-or-lose" rule under applicable tax laws and it is one of the required trade-offs for the tax benefits gained. In other words, you cannot be reimbursed for (or receive any direct or indirect payment of) any amounts that were not incurred for Medical Care Expenses during the Plan Year , even if amounts are still left in your Health FSA. The difference between what you elected and what Medical Care Expenses were reimbursed will be forfeited at the end of the time limits described in HFSA Q-12.

HFSA Q-12. What are the time limits that affect forfeiture of my Health FSA Benefits (and what happens to amounts that are forfeited)?

Subject to any rollover provisions in HFSA Q-11, you will forfeit any amounts in your Health FSA Account that are not applied to pay expenses submitted by 3 month(s) after the close of the Plan Year for which the election was effective (except that if you have ceased to be eligible as a Participant, you may forfeit such amounts at an earlier date—see HFSA Q-9).

Forfeited amounts will be used as follows: first, to offset any losses experienced by the Employer as a result of making reimbursements in excess of contributions paid by all Participants; second, to reduce the cost of administering the Health FSA during the Plan Year and subsequent Plan Year; and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations.

HFSA Q-13. Will I be taxed on the Health FSA Benefits that I receive?

Generally, you will not be taxed on your Health FSA Benefits, up to the limits set forth in HFSA Q-4. However, the Employer cannot guarantee that specific tax consequences will flow

from your participation in the Plan. The tax benefits that you receive depend on the validity of the claims that you submit. For example, to qualify for tax-free treatment, your Medical Care Expenses must meet the definition of "medical care" as defined in the Code. If you are reimbursed for a claim that is later determined to not be for eligible Medical Care Expenses, then you will be required to repay the amount.

Ultimately, it is your responsibility to determine whether any reimbursement under the Health FSA constitutes Medical Care Expenses that qualify for the federal income tax exclusion. Ask the Plan Administrator if you need further information about which expenses are—and are not—likely to be reimbursable, but remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

HFSA Q-14. Can I cover Dependents until they are 27 with my Health FSA?

Medical Care Expenses incurred for children of Participants who will have not attained age 27 by the end of any given taxable year may be reimbursed by the Health FSA.

DCAP Benefits

DCAP Q-1. What are "DCAP Benefits"?

As described in CAF Q-2, a DCAP permits eligible Employees to pay for coverage with pre-tax dollars that will reimburse them for Dependent Care Expenses not reimbursed elsewhere (for example, you cannot be reimbursed for the same expense from your Spouse's DCAP).

As described in CAF Q-1, if you elect DCAP Benefits, then you will be able to provide a source of pre-tax funds to reimburse yourself for your eligible Dependent Care Expenses by entering into a Salary Reduction Agreement with your Employer. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA taxes.

See CAF Q-4 for an example dealing with pre-tax payment of Health Insurance contributions.

DCAP Q-2. Reserved for future content

DCAP Q-3. What is my "DCAP Account"?

If you elect DCAP Benefits, an account called a "DCAP Account" will be set up in your name to keep a record of the reimbursements that you are entitled to, as well as the contributions that you have paid for such benefits during the Plan Year. Your DCAP Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general

assets of the Employer) and it does not bear interest.

DCAP Q-4. What are the maximum DCAP Benefits that I may elect under the Cafeteria Plan?

You may choose any amount of Dependent Care Expenses reimbursement that you desire under the DCAP, subject to the minimum reimbursement amount of $5.00 and the maximum reimbursement amount described below. You must commit to a salary reduction to pay the annual DCAP contribution equal to the coverage level that you have chosen (e.g., if you elect $3,000 in DCAP Benefits, you'll pay for the benefits with a $3,000 salary reduction).

If you enter the DCAP Component mid-year, then the Participant's maximum reimbursement dollar limit will be prorated based on a percentage of the Plan Year remaining.

The amount of Dependent Care Expense reimbursement that you choose cannot exceed the lower of the Employer's established maximum $7,500.00, statutory maximum of $7,500 for a calendar year or, if lower, the maximum amount that you have reason to believe will be excludable from your income under Code § 129 when your election is made. The $7,500 maximum will apply to you if:

• you are married and file a joint federal income tax return;

• you are married and file a separate federal income tax return, and meet the following conditions: (1) you maintain as your home a household that constitutes (for more than half of the taxable year) the principal place of abode of a Qualifying Individual (i.e., the Dependent for whom you are eligible to receive reimbursements under the DCAP); (2) you furnish over half of the cost of maintaining such household during the taxable year; and (3) during the last six months of the taxable year, your Spouse is not a member of such household (i.e., your Spouse maintained a separate residence); or you are single or the head of the household for federal income tax purposes.

If you are married and reside with your Spouse but you file a separate federal income tax return, then the maximum DCAP Benefit that you may exclude from your income under Code § 129 is $3,750 for a calendar year. These maximums ($7,500 or $3,750 for a calendar year, as applicable) are just the largest amount that is possible; the maximum amount that you are able to exclude from your income may be less because of other limitations, as described in DCAP Q-7 (for example, note that you cannot exclude more than the amount of your or your Spouse's earned income for the calendar year).

DCAP Q-5 How are my DCAP Benefits paid for under the Cafeteria Plan?

When you complete your Salary Reduction Agreement, you specify the amount of DCAP Benefits that you wish to pay with your salary reduction. From then on, you must pay a

contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator). If you pay all of your contributions, then your DCAP Account will be credited with the portion of your gross income that you have elected to give up through salary reduction. These portions will be credited as of each pay period.

For example, suppose that you have elected to be reimbursed for $5,000 per year for Dependent Care Expenses and that you have chosen no other benefits under the Cafeteria Plan. Your DCAP Account would be credited with a total of $5,000 by the end of the Plan Year. If you are paid biweekly, then your DCAP Account would reflect that you have paid $192.31 ($5,000 divided by 26) each pay period in contributions for the DCAP Benefits that you have elected.

DCAP Q-6. What amounts will be available for DCAP reimbursement at any particular time during the Plan Year?

The amount of coverage that is available for reimbursement of qualifying Dependent Care Expenses at any particular time during the Plan Year will be equal to the amount credited to your DCAP Account at the time your claim is paid, reduced by the amount of any prior reimbursements paid to you during the Plan Year.

Using the example in DCAP Q-5, suppose that you incur $1,500 of Dependent Care Expenses by the end of the third month of the Plan Year. Assuming you have had seven pay periods at that point, your DCAP Account would only have been credited with $1,346.15 ($192.31 times seven pay periods), so only $1,346.15 would be available for reimbursement at the end of March (assuming that you had not received any prior reimbursements). You would have to wait to submit the remaining balance of your Dependent Care Expenses until after you had received the appropriate credits to your DCAP Account.

You may also be able to be reimbursed from unused amounts remaining in your DCAP Account at the end of a Plan Year for Dependent Care Expenses incurred during a "grace period" following the end of the Plan Year (See DCAP Q-8).

DCAP Q-7. What are “Dependent Care Expenses” that may be reimbursed?

“Dependent Care Expenses” means employment-related expenses incurred on behalf of a person who meets the requirements to be a “Qualifying Individual,” as defined in the first bulleted item below. All of the following conditions must be met for such expenses to qualify as Dependent Care Expenses that are eligible for reimbursement:

• Each person for whom you incur the expenses must be a Qualifying Individual—that is, he or she must be:

    • a person under age 13 who is your “qualifying child” under the Code (in general,

the person must: (1) have the same principal abode as you for more than half the year; (2) be your child or stepchild (by blood or adoption), foster child, sibling or stepsibling, or a descendant of one of them; and (3) not provide more than half of his or her own support for the year);

• your Spouse who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than half of the year; or

• a person who is physically or mentally incapable of caring for himself or herself, has the same principal place of abode as you for more than half of the year, and is your tax dependent under the Code (for this purpose, status as a tax dependent is determined without regard to the gross income limitation for a "qualifying relative" and certain other provisions of the Code's definition).

Under a special rule for children of divorced or separated parents, a child is a Qualifying Individual with respect to the custodial parent when the noncustodial parent is entitled to claim the dependency exemption for the child.

• No reimbursement will be made to the extent that such reimbursement would exceed the balance in your DCAP Account.

• The expenses are incurred for services rendered after the date of your election to receive DCAP Benefits and during the Plan Year to which the election applies.

• The expenses are incurred in order to enable you (and your Spouse, if you are married) to be gainfully employed, which generally means working or looking for work. There is an exception: If your Spouse is not working or looking for work when the expenses are incurred, he or she must be a full-time student or be physically or mentally incapable of self-care.

• The expenses are incurred for the care of a Qualifying Individual or for household services attributable in part to the care of a Qualifying Individual.

If the expenses are incurred for services outside of your household for the care of a Qualifying Individual other than a person under age 13 who is your qualifying child, then the Qualifying Individual must regularly spend at least eight hours per day in your household.

If the expenses are incurred for services provided by a dependent care center (that is, a facility that provides care for more than six individuals not residing at the facility), the center must comply with all applicable state and local laws and regulations.

• The person who provided care was not your Spouse, a parent of your under-age-13 qualifying child, or a person for whom you (or your Spouse) are entitled to a personal exemption under Code § 151(c). If your child provided the care, then he or she must be age 19 or older at the end of the year in which the expenses are incurred.

• The expenses are not paid for services outside of your household at a camp where the Qualifying Individual stays overnight.

Ask the Plan Administrator if you need further information about which expenses are—and are not—likely to be reimbursable, but remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

You will also be asked to certify that you have no reason to believe that the requested reimbursement, when added to your other reimbursements to date for Dependent Care Expenses incurred during the same calendar year, will exceed the applicable statutory limit. Your statutory limit is the smallest of the following amounts:

- your earned income for the calendar year (after your salary reductions under the Cafeteria Plan);
- the earned income of your Spouse for the calendar year (your Spouse will be deemed to have earned income of $250 ($500 if you have two or more Qualifying Individuals) for each month in which your Spouse is (a) physically or mentally incapable of self-care; or (b) a full-time student); or
- either $7,500 or $3,750 for the calendar year, depending on your marital and tax filing status, as described further in DCAP Q-4.

Any reimbursements that the Employer has reason to believe will exceed your statutory limit will be subject to FICA and income tax withholding. Note that if you are married and your Spouse also participates in a DCAP, the maximum amount that you and your Spouse together can exclude from income is $7,500.

DCAP Q-8. When must the Dependent Care Expenses be incurred?

For Dependent Care Expenses to be reimbursed to you from your DCAP Account for the Plan Year, the expenses must have been incurred during that Plan Year. The Plan Year for the DCAP is the same as for the Cafeteria Plan—it is the 12-month period beginning on January 1 and ending on December 31.

In addition, as discussed below, you may be able to be reimbursed from unused amounts remaining in your DCAP Account at the end of a Plan Year for Dependent Care Expenses incurred during a "grace period" following the end of the Plan Year. Grace periods will begin immediately following the last day of the plan year and will end two months and fifteen days later.

A Dependent Care Expense is incurred when the service that causes the expense is provided, not when the expense is paid. If you have paid for the expense but the services have not yet been rendered, then the expense has not been incurred. For example, if you

prepay on the first day of the month for dependent care that will be given during the rest of the month, then the expense is not incurred until the end of that month (and cannot be reimbursed until after the end of that month). You may not be reimbursed for any expenses arising before the DCAP or Cafeteria Plan became effective, for any expenses arising before your Election Form/Salary Reduction Agreement became effective, for any expenses incurred after the close of the Plan Year, or after a separation from service (except as described in DCAP Q-9).

DCAP Q-9. What must I do to be reimbursed for my Dependent Care Expenses?

Except in cases where an electronic payment card (or "debit card") is used, when you incur an expense that is eligible for payment, you must submit a claim to the Plan Administrator (or Third Party Administrator, if applicable) on a DCAP Reimbursement Request Form that will be supplied to you. You must include written statements and/or bills from independent third parties stating that the Dependent Care Expenses have been incurred and stating the amount of such Dependent Care Expenses, along with the DCAP Reimbursement Request Form. Further details about what must be provided are contained in the DCAP Reimbursement Request Form.

If there are enough credits to your DCAP Account, then you will be reimbursed for your eligible DCAP Expenses within 30 days after the date you submitted the DCAP Reimbursement Request Form (subject to a 15-day extension in certain instances—see CAF Q-11). If a claim is for an amount larger than that remaining in your current DCAP Account balance, then the excess part of the claim will be carried over into the following months, to be paid out as your balance becomes adequate. Remember, though, that you can't be reimbursed for any total expenses above your available annual credits to your DCAP Account.

You will have 3 month(s) after the end of the Plan Year in which to submit a claim for reimbursement for Dependent Care Expenses incurred during the previous Plan Year. However, if you have ceased to be eligible as a Participant, you will only have until 1 month(s) after the date you ceased to be eligible in which to submit a claim for reimbursement for Dependent Care Expenses incurred prior to the date you ceased to be eligible. You will be notified in writing if any claim for benefits is denied. (See CAF Q-11.)

The following additional rules will apply to Dependent Care Expenses that are incurred during a grace period or are submitted after the close of the Plan Year in which they were incurred:

• Dependent Care Expenses incurred during a grace period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the preceding Plan Year and then from any amounts that are available to reimburse expenses incurred during the current Plan Year. For example, assume that $200 remains in your DCAP Account at the end of the current Plan Year and that you have also elected

$2,400 of DCAP coverage for the new Plan Year. If you submit a $500 Dependent Care Expense that was incurred on January 15, of the new Plan Year, $200 of your claim will be paid out of the unused amounts remaining in your DCAP Account from the current Plan Year and the remaining $300 will be paid out of the amounts that are available to reimburse you for Dependent Care Expenses incurred in the new Plan Year.

• Once paid, a claim will not be reprocessed or otherwise re-characterized so as to change the Plan Year from which funds are taken to pay it. For example, using the same facts as in the example in the preceding paragraph, assume that a few days after being reimbursed for the $500 grace period expense, you discover $200 of prior Plan Year expenses Dependent Care Expenses that have not been submitted for reimbursement. You cannot be reimbursed for the newly discovered expenses because no amounts remain to reimburse you from your current Plan Year funds. The Plan will not reprocess the $500 grace period expense so as to pay it entirely from your current Plan Year Dependent Care amounts. For this reason, if you also have Dependent Care coverage for the current year, you may want to wait to submit Dependent Care Expenses you incur during the grace period until you are sure you have no remaining unreimbursed expenses from the prior Plan Year.

• Expenses incurred during a grace period must be submitted by the 90 day(s) following the close of the Plan Year to which the grace period relates in order to be reimbursed from amounts remaining at the end of that Plan Year. (As discussed above, 90 days is also the deadline for submitting any claims for reimbursement of Dependent Care Expenses incurred during the preceding Plan Year.)

To have your claims processed as soon as possible, please read CAF Q-11. Note that it is not necessary for you to have actually paid the bill in an amount due for a Dependent Care Expense, only for you to have incurred the expense (as defined in DCAP Q-8) and that it is not being paid for or reimbursed from any other source.

If the Employer implements an electronic payment card program (debit card, credit card, or similar method) to pay expenses from the Dependent Care Account, some expenses may be validated at the time the expense is incurred. For other expenses, the card payment is only conditional and you will still have to submit supporting documents. In addition, Dependent Care Expenses incurred during a Grace Period may need to be submitted manually in order to be reimbursed from unused amounts in your Dependent Care Account from the preceding Plan Year if the card is unavailable for such reimbursement.

DCAP Q-10. Is there any risk of losing or forfeiting the amounts that I elect for DCAP Benefits?

Yes. If the Dependent Care Expenses that you incur during the Plan Year or during the grace period immediately following the Plan Year (if you are eligible for the grace period—see DCAP Q-8) are less than the annual amount that you elected for DCAP Benefits, you will forfeit the rest of that amount—this is called the “use-or-lose” rule under applicable tax

laws and it is one of the required trade-offs for the tax benefits gained. In other words, you cannot be reimbursed for (or receive any direct or indirect payment of) any amounts that were not incurred for Dependent Care Expenses during the Plan Year or its grace period (if applicable), even if amounts are still left in your DCAP Account. The difference between what you elected and what Dependent Care Expenses were reimbursed will be forfeited at the end of the time limits described in DCAP Q-11.

DCAP Q-11. What are the time limits that affect forfeiture of my DCAP Benefits?

You will forfeit any amounts in your DCAP Account that are not applied to DCAP Benefits for any Plan Year within 3 month(s) after the end of the Plan Year for which the election was effective (except that if you have ceased to be eligible as a Participant, you will forfeit such amounts if they have not been applied within 1 month(s) after the date you ceased to be eligible—see DCAP Q-9). Forfeited amounts will be used as follows: first, to offset any losses experienced by the Employer as a result of making reimbursements in excess of contributions paid by all Participants; second, to reduce the cost of administering the DCAP during the Plan Year and the subsequent Plan Year; and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations.

DCAP Q-12. Will I be taxed on the DCAP Benefits I receive?

Generally, you will not be taxed on your DCAP Benefits, up to the limits set forth in Q-4. However, the Employer cannot guarantee that specific tax consequences will flow from your participation in the DCAP. The tax benefits that you receive depend on the validity of the claims that you submit. For example, for tax-free treatment, you will be required to file IRS Form 2441 ("Child and Dependent Care Expenses") with your annual tax return (Form 1040) or a similar form. You must list on Form 2441 the names and taxpayer identification numbers (TINs) of any entities that provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement. If you are reimbursed for a claim that is later determined to not be for Dependent Care Expenses, then you will be required to repay the amount.

Ultimately, it is your responsibility to determine whether any reimbursement under the DCAP constitutes Dependent Care Expenses that qualify for the federal income tax exclusion. Ask the Plan Administrator if you need further information about which expenses are—and are not—likely to be reimbursable, but remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

DCAP Q-13. If I elect DCAP Benefits, can I still claim the Dependent Care Tax Credit on my federal income tax return?

You may not claim any other tax benefit for the amount of your pre-tax salary reductions

under the DCAP, although your Dependent Care Expenses in excess of that amount may be eligible for the Dependent Care Tax Credit (see DCAP Q-14). For example, if you elect $3,000 in coverage under the DCAP and are reimbursed $3,000, but you had Dependent Care Expenses totaling $5,000, then you could count the excess $2,000 when calculating the Dependent Care Tax Credit if you have two or more Qualifying Individuals.

DCAP Q-14. What is the Dependent Care Tax Credit?

The Dependent Care Tax Credit is a credit against your federal income tax liability under the Code. It is a non-refundable tax credit, which means that any portion of it that exceeds your federal income tax liability will be of no value to you. The credit is calculated as a percentage of your annual Dependent Care Expenses. In determining what the tax credit would be, you may take into account $3,000 of such expenses for one Qualifying Individual, or $6,000 for two or more Qualifying Individuals. Depending on your adjusted gross income, the percentage could be as much as 35% of your qualifying expenses (to a maximum credit amount of $1,050 for one Qualifying Individual, or $2,100 for two or more Qualifying Individuals), to a minimum of 20% of such expenses (producing a maximum credit of $600 for one Qualifying Individual, or $1,200 for two or more Qualifying Individuals). The maximum 35% rate is reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) by which your adjusted gross income exceeds $15,000.

For more information about how the Dependent Care Tax Credit works, see IRS Publication No. 503 ("Child and Dependent Care Expenses"). You may also wish to consult a tax advisor, as discussed below.

DCAP Q-15. Would it be better to include the DCAP Benefits in my income and claim the Dependent Care Tax Credit, instead of treating the reimbursements as tax free?

For most individuals, participating in a DCAP will produce the greater federal tax savings, but there are some for whom the opposite is true. (And in some cases, the federal tax savings from participating in a DCAP will be only marginally better.) Because the preferable method for treating benefits payments depends on certain factors such as a person's tax filing status (e.g., married, single, head of household), number of Qualifying Individuals, earned income, etc., each Participant will have to determine his or her tax position individually in order to make the decision. Use IRS Form 2441 ("Child and Dependent Care Expenses") to help you.

Miscellaneous

MISC Q-1. Reserved for future content.

MISC Q-2. What other general information should I know?

This MISC Q-2 contains certain general information that you may need to know about the Plan. Note: This Summary Plan Description does not describe the Medical Insurance Plan. Consult the Medical Insurance Plan documents and the separate Summary Plan Description for the Medical Insurance Plan. Neither does this Summary Plan Description describe many aspects of your HSA (e.g., with respect to investments or distributions). Consult the HSA trust or custodial documents provided by the applicable trustee/custodian.

General Plan Information

Official Name of the Plan: CITY OF JACKSONVILLE Cafeteria Plan

Plan Number: 501

Effective Date: January 1, 2023.

Plan Year: January 1 to December 31. Your Plan's records are maintained on this period of time.

Type of Plan: Welfare plan providing Health FSA Benefits and DCAP Benefits

Employer/Plan Sponsor Information

Name and Address:

CITY OF JACKSONVILLE

117 W. Duval St, Suite 150

Jacksonville, FL 32202

Federal employee tax identification number (EIN): 596000344 .

Plan Administrator Information

Name, address, and business telephone number:

CITY OF JACKSONVILLE

117 W. Duval St, Suite 150

Jacksonville, FL 32202

Attention: Human Resources

Telephone Number: (904) 255-8830

Funding Medium and Type of Plan Administration.

The Health FSA Component is a group health plan. The Health FSA is self-funded by the Employer. It is a contract administration plan. A third-party administrator processes claims

for the Plan, but the Employer pays all claims out of its general assets. A health insurance issuer is not responsible for the financing or administration (including payment of claims) of the Plan.

Named Fiduciary

The named fiduciary for the Health FSA Component is:

CITY OF JACKSONVILLE

117 W. Duval St, Suite 150

Jacksonville, FL 32202

Telephone Number: (904) 255-8830

Agent for Service of Legal Process

The name and address of the Plan's agent for service of legal process is:

CITY OF JACKSONVILLE

117 W. Duval St, Suite 150

Jacksonville, FL 32202

Attention: Benefits Committee

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or to less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Medical Insurance Plan and HSA Documents and Information

This Summary Plan Description does not describe the Medical Insurance Plan. Consult the Medical Insurance Plan document and the separate Summary Plan Description for the Medical Insurance Plan. Neither does this Summary Plan Description describe many aspects of the HSA Component (e.g., with respect to claims and reimbursement under the HSA). Consult the HSA trust or custodial documents provided by the applicable trustee/custodian.

Appendix A

CONTINUATION COVERAGE RIGHTS UNDER COBRA CITY OF JACKSONVILLE Cafeteria Plan (the "**Plan"**)

Introduction

The following paragraphs generally explain COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The Plan may have one or more of the following group health components: Medical, Dental, Vision and/or Health FSA. You may be enrolled in one or more of these components. COBRA (and the description of COBRA coverage contained in this SPD) applies only to the group health plan benefits offered under the Plan (the Medical, Dental, and Health FSA components) and not to any other benefits offered under the Plan or by CITY OF JACKSONVILLE. The Plan provides no greater COBRA rights than what COBRA requires—nothing in this SPD is intended to expand your rights beyond COBRA's requirements.

You May Have Other Options Available to You When You Lose Group Health Coverage

For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What Is COBRA Coverage?

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below in the section entitled "Who Is Entitled to Elect COBRA?"

COBRA coverage may become available to "qualified beneficiaries"

After a qualifying event occurs and any required notice of that event is properly provided to CITY OF JACKSONVILLE, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is

discussed in more detail in separate paragraphs below.)

COBRA Coverage Under the Health FSA Component

COBRA coverage is offered only in limited circumstances

COBRA coverage under the Health FSA will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered employee, reduced by the reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for Health FSA COBRA coverage that will be charged for the remainder of the plan year.

Health FSA COBRA coverage lasts only until the end of the plan year

COBRA coverage will consist of the Health FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by the reimbursable claims submitted up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and COBRA coverage will terminate at the end of the plan year.

All qualified beneficiaries are covered together under the Health FSA unless otherwise elected

Unless otherwise elected, all qualified beneficiaries who were covered under the Health FSA will be covered together for Health FSA COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate Health FSA annual limit and a separate premium. If you are interested in this alternative, contact CITY OF JACKSONVILLE for more information.

No Health FSA open enrollment

Qualified beneficiaries may not enroll in the Health FSA at open enrollment.

Who Is Entitled to Elect COBRA?

We use the pronoun “you” in the following paragraphs regarding COBRA to refer to each person covered under the Plan who is or may become a qualified beneficiary.

Qualifying events for the covered employee

If you are an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because either one of the following qualifying events happens: • your hours of employment are reduced; or • your employment ends for any reason other than your gross misconduct.

Qualifying events for the covered spouse

If you are the spouse of an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happens:

• your spouse dies;

• your spouse's hours of employment are reduced;

• your spouse's employment ends for any reason other than his or her gross misconduct; or

• you become divorced or legally separated from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

Qualifying events for dependent children

If you are the dependent child of an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happens:

• your parent-employee dies;

• your parent-employee's hours of employment are reduced;

• your parent-employee's employment ends for any reason other than his or her gross misconduct;

• you stop being eligible for coverage under the Plan as a "dependent child."

Electing COBRA after leave under the Family and Medical Leave Act (FMLA)

Under special rules that apply if an employee does not return to work at the end of an FMLA leave, some individuals may be entitled to elect COBRA even if they were not covered under the Plan during the leave. Contact CITY OF JACKSONVILLE or the third party COBRA administrator for more information about these special rules.

Special second election period for certain eligible employees who did not elect COBRA

Certain employees and former employees who are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA) are entitled to a second opportunity to elect COBRA for themselves and certain family members (if they did not already elect COBRA) during a special second election period of 60 days or less (but only if the election is made within six months after Plan coverage is lost). If you are an employee or former employee and you qualify for TAA or ATAA,

CONTACT CITY OF JACKSONVILLE PROMPTLY AFTER QUALIFYING FOR TAA OR ATAA OR YOU WILL LOSE ANY RIGHT THAT YOU MAY HAVE TO ELECT COBRA DURING A SPECIAL SECOND ELECTION PERIOD.

Contact CITY OF JACKSONVILLE for more information about the special second election period.

When Is COBRA Coverage Available?

When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. You need not notify CITY OF JACKSONVILLE of any of these qualifying events.

Caution:

You stop being eligible for coverage as dependent child whenever you fail to satisfy any part of the plan's definition of dependent child.

You must notify the plan administrator of certain qualifying events by this deadline

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available to you only if you notify CITY OF JACKSONVILLE in writing within 60 days after the later of (1) the date of the qualifying event; or (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

No COBRA election will be available unless you follow the Plan's notice procedures and meet the notice deadline

In providing this notice, you must use the Plan's form entitled "Notice of Qualifying Event Form"

You may obtain a copy of this form from CITY OF JACKSONVILLE at no charge, and you must follow the notice procedures specified in the section below entitled "Notice Procedures." If these procedures are not followed or if the notice is not provided to CITY OF JACKSONVILLE during the 60-day notice period, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA. Electing COBRA Coverage

How to elect COBRA

To elect COBRA, you must complete and return the Election Form in the manner outlined in the Plan's COBRA election notice.

An election notice will be provided to qualified beneficiaries at the time of a qualifying event. You may also obtain a copy of the Election Form from CITY OF JACKSONVILLE.

Deadline for COBRA election

If mailed, your election must be postmarked (or if hand-delivered, your election must be received by the individual at the address specified on the Election Form) no later than 60 days after the date of the COBRA election notice provided to you at the time of your qualifying event (or, if later, 60 days after the date that Plan coverage is lost). IF YOU DO NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.

Independent election rights

Each qualified beneficiary will have an independent right to elect COBRA.

Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.

Special Considerations in Deciding Whether to Elect COBRA

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

Length of COBRA Coverage

COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described below are maximum coverage periods.

COBRA coverage under the Health FSA component can last only until the end of the year in which the qualifying event occurred—see the section above entitled "COBRA Coverage Under the Health FSA Component."

COBRA coverage can end before the end of the maximum coverage period for several reasons, which are described in the section below entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

Death, divorce, legal separation, or child's loss of dependent status

When Plan coverage is lost due to the death of the employee, the covered employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA coverage under the Plan's Medical and Dental components can last for up to a total of 36 months.

If the covered employee becomes entitled to Medicare within 18 months before his or her termination of employment or reduction of hours.

When Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage under the Plan's Medical and Dental components for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA coverage for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

Termination of employment or reduction of hours

Otherwise, when Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, COBRA coverage under the Plan's Medical and Dental components generally can last for only up to a total of 18 months.

Extension of Maximum Coverage Period (Not Applicable to Health FSA Component)

If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify CITY OF JACKSONVILLE of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA coverage. (The period of COBRA coverage under the Health FSA cannot be extended under any circumstances. These extension opportunities also do not apply to a period of COBRA coverage resulting from a covered employee's death, divorce, or legal separation or a dependent child's loss of eligibility.)

Disability extension of COBRA coverage

If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify CITY OF JACKSONVILLE in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the covered employee's termination of

employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

You must notify CITY OF JACKSONVILLE of a qualified beneficiary's disability by this deadline

The disability extension is available only if you notify CITY OF JACKSONVILLE in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

• the date of the Social Security Administration's disability determination;

• the date of the covered employee's termination of employment or reduction of hours; and

• the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension.

No disability extension will be available unless you follow the Plan's notice procedures and meet the notice deadline

In providing this notice, you must use the Plan's form entitled "Notice of Disability Form" (you may obtain a copy of this form from CITY OF JACKSONVILLE at no charge, and you must follow the notice procedures specified in the section below entitled "Notice Procedures."

If these procedures are not followed or if the notice is not provided to CITY OF JACKSONVILLE during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.

Second qualifying event extension of COBRA coverage

An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when a covered

employee becomes entitled to Medicare after his or her termination of employment or reduction of hours.)

You must notify CITY OF JACKSONVILLE of a second qualifying event by this deadline

This extension due to a second qualifying event is available only if you notify CITY OF JACKSONVILLE in writing of the second qualifying event within 60 days after the date of the second qualifying event.

No extension will be available unless you follow the Plan's notice procedures and meet the notice deadline

In providing this notice, you must use the Plan's form entitled "Notice of Second Qualifying Event Form" (you may obtain a copy of this form from CITY OF JACKSONVILLE at no charge, and you must follow the notice procedures specified in the section below entitled "Notice Procedures." If these procedures are not followed or if the notice is not provided to CITY OF JACKSONVILLE during the 60-day notice period, THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.

Termination of COBRA Coverage Before the End of the Maximum Coverage Period

COBRA coverage will automatically terminate before the end of the maximum period if:

• any required premium is not paid in full on time;

• a qualified beneficiary becomes covered, after electing COBRA, under another group health plan;

• a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA;

• the employer ceases to provide any group health plan for its employees; or

• during a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, will terminate). For more information about the disability extension period, see the section above entitled "Extension of Maximum Coverage Period (Not Applicable to Health FSA Component)."

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

You must notify CITY OF JACKSONVILLE if a qualified beneficiary becomes entitled to Medicare or obtains other group health plan coverage

You must notify CITY OF JACKSONVILLE in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes

covered under other group health plan coverage. You must use the Plan's form entitled "Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability Form" (you may obtain a copy of this form from CITY OF JACKSONVILLE at no charge, and you must follow the notice procedures specified below in the section entitled "Notice Procedures." In addition, if you were already entitled to Medicare before electing COBRA, notify CITY OF JACKSONVILLE of the date of your Medicare entitlement at the address shown in the section below entitled "Notice Procedures."

You must notify CITY OF JACKSONVILLE if a qualified beneficiary ceases to be disabled

If a disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify CITY OF JACKSONVILLE of that fact within 30 days after the Social Security Administration's determination. You must use the Plan's form entitled "Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability Form" (you may obtain a copy of this form from CITY OF JACKSONVILLE at no charge, and you must follow the notice procedures specified below in the section entitled "Notice Procedures."

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to a disability, 150%) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage. The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

Payment for COBRA Coverage

How premium payments must be made

All COBRA premiums must be paid by check. Your first payment and all monthly payments for COBRA coverage must be mailed or hand-delivered to the individual at the payment address specified in the election notice provided to you at the time of your qualifying event. However, if the Plan notifies you of a new address for payment, you must mail or hand-deliver all payments for COBRA coverage to the individual at the address specified in that notice of a new address.

When premium payments are considered to be made

If mailed, your payment is considered to have been made on the date that it is postmarked. If hand-delivered, your payment is considered to have been made when it is received by the individual at the address specified above. You will not be considered to have made any payment by mailing or hand-delivering a check if your check is returned due to insufficient funds or otherwise.

First payment for COBRA coverage

If you elect COBRA, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage not later than 45 days after the date of your election. (This is the date your Election Form is postmarked, if mailed, or the date your Election Form is received by the individual at the address specified for delivery of the Election Form, if hand-delivered.) See the section above entitled "Electing COBRA Coverage."

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. (For example, Sue's employment terminates on September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of her COBRA election.)

You are responsible for making sure that the amount of your first payment is correct. You may contact CITY OF JACKSONVILLE using the contact information provided below to confirm the correct amount of your first payment. Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.

Monthly payments for COBRA coverage

After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided to you at the time of your qualifying event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without any break. CITY OF JACKSONVILLE will not send periodic notices of payments due for these coverage periods (that is, we will not send a bill to you for your COBRA coverage—it is your responsibility to pay your COBRA premiums on time).

Grace periods for monthly COBRA premium payments

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it

applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.

More Information About Individuals Who May Be Qualified Beneficiaries

Children born to or placed for adoption with the covered employee during a period of COBRA coverage

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Alternate recipients under QMCSOs

A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by CITY OF JACKSONVILLE during the covered employee's period of employment with CITY OF JACKSONVILLE is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

Are There Other Coverage Options Besides COBRA Coverage?

Yes. Instead of enrolling in COBRA coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA coverage. You can learn more about many of these options at www.HealthCare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security

Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

NOTICE PROCEDURES

CITY OF JACKSONVILLE Welfare Benefits Plan (the Plan)

Warning If your notice is late or if you do not follow these notice procedures, you and all related qualified beneficiaries will lose the right to elect COBRA (or will lose the right to an extension of COBRA coverage, as applicable).

Notices Must Be Written and Submitted on Plan Forms

Any notice that you provide must be in writing and must be submitted on the Plan's required form (the Plan's required forms are described above in this SPD, and you may obtain copies from CITY OF JACKSONVILLE without charge. Oral notice, including notice by telephone, is not acceptable.

How, When, and Where to Send Notices

You must mail or hand-deliver your notice to:

Human Resources Manager (or similar Employer Representative)

CITY OF JACKSONVILLE

117 W. Duval St, Suite 150

Jacksonville, FL 32202

However, if a different address for notices to the Plan appears in the Plan's most recent summary plan description, you must mail or hand-deliver your notice to that address (if you do not have a copy of the Plan's most recent summary plan description, you may request one from CITY OF JACKSONVILLE).

If mailed, your notice must be postmarked no later than the last day of the applicable notice period. If hand-delivered, your notice must be received by the individual at the address specified above no later than the last day of the applicable notice period. (The applicable notice periods are described in the paragraphs above entitled "You must notify the plan administrator of certain qualifying events by this deadline," "You must notify CITY OF JACKSONVILLE of a qualified beneficiary's disability by this deadline," and "You must notify CITY OF JACKSONVILLE of a second qualifying event by this deadline.")

Information Required for All Notices

Any notice you provide must include (1) the name of the Plan (CITY OF JACKSONVILLE

Welfare Benefits Plan); (2) the name and address of the employee who is (or was) covered under the Plan; (3) the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage as a result of the qualifying event; (4) the qualifying event and the date it happened; and (5) the certification, signature, name, address, and telephone number of the person providing the notice.

Additional Information Required for Notice of Qualifying Event

If the qualifying event is a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation. If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and if you are notifying CITY OF JACKSONVILLE that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, your notice must include evidence satisfactory to CITY OF JACKSONVILLE that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

Additional Information Required for Notice of Disability

Any notice of disability that you provide must include (1) the name and address of the disabled qualified beneficiary; (2) the date that the qualified beneficiary became disabled; (3) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (4) the date that the Social Security Administration made its determination; (5) a copy of the Social Security Administration's determination; and (6) a statement whether the Social Security Administration has subsequently determined that the disabled qualified beneficiary is no longer disabled.

Additional Information Required for Notice of Second Qualifying Event

Any notice of a second qualifying event that you provide must include (1) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (2) the second qualifying event and the date that it happened; and (3) if the second qualifying event is a divorce or legal separation, a copy of the decree of divorce or legal separation.

Who May Provide Notices

The covered employee, a qualified beneficiary who lost coverage due to the qualifying event described in the notice, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

Appendix B

HIPAA NOTICE OF PRIVACY PRACTICES THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This HIPAA Notice of Privacy Practices (the **"Notice"**) contains important information about your medical information. You have the right to receive a paper copy of this Notice and may ask us to give you a copy of this Notice at any time. If you received this Notice electronically, you are entitled to a paper copy of this Notice. If you have any questions about this Notice, please contact the person listed in Part 8, below.

The Health Insurance Portability and Accountability Act of 1996 (**"HIPAA"**) imposes numerous requirements on employer health plans regarding how certain individually identifiable health information—known as protected health information (or PHI)—may be used and disclosed.

This Notice describes how the CITY OF JACKSONVILLE Health Reimbursement Arrangement ([collectively,] the **"Plans"**), and any third party that assists in the administration of the Plan, may use and disclose your protected health information for treatment, payment, or health care operations and for other purposes that are permitted or required by law.

This Notice also describes your rights to access and control your protected health information. **"Protected health information"** is information that is maintained or transmitted by the Plans, which may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you and will use it to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request of it. [We create a record of the health care claims reimbursed under the Flexible Spending Account for the Plans' administration purposes.]

This Notice applies to all of the medical records we maintain. For insured Group Medical Plans, our insurers' Notices of Privacy Practices will apply, except for the limited medical information the Group Medical Plans may receive and maintain from you when you ask us to assist you in a claims processing or benefit determination dispute, information related to your enrollment or disenrollment in the Group Medical Plans, and certain summary health information.

This Notice will only apply to a Group Medical Plan to the extent it has such medical information related to you.

Your personal doctor or health care provider may have different policies or notices about how they use and disclose your medical information. We are required by law to abide by the

terms of this Notice to:

- Make sure that medical information that identifies you is kept private.
- Give you this Notice of our legal duties and privacy practices regarding medical information about you.
- Follow the terms of the Notice that is currently in effect.

Please note: These rules apply to the Plans, not CITY OF JACKSONVILLE as an employer.

1. How We May Use and Disclose Medical Information About You. HIPAA generally permits the use and disclosure of your health information without your permission for purposes of health care treatment, payment activities, and health care operations. These uses and disclosures are more fully described below. This Notice does not list every use or disclosure; instead it gives examples of the most common uses and disclosures.

• **Treatment:** When and as appropriate, we may use or disclose medical information about you to facilitate medical treatment or services by health care providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about you with physicians who are treating you.

• **Payment:** When and as appropriate, we may use and disclose medical information about you to determine your eligibility for the Plans' benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility and coverage under the Plans, or to coordinate your coverage. For example, we may disclose information about your medical history to a physician (including your physician) to determine whether a particular treatment is experimental, investigational, or medically necessary, or to decide if the Plans will cover the treatment. Additionally, we may share medical information with another entity to assist with the adjudication or subrogation of health claims, or with another health plan to coordinate benefit payments.

• **Health Care Operations:** When and as appropriate, we may use and disclose medical information about you for the Plans' operations, as needed. For example, we may use medical information in connection with: conducting quality assessment and administration improvement; underwriting, premium rating, and other activities relating to coverage; submitting claims for stop loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general administrative activities of the Plans. For example, we may use your information to review the effectiveness of wellness programs or in negotiating new arrangements with our current or new insurers. We will not use or disclose your genetic information for underwriting purposes.

We will always try to ensure that the medical information used or disclosed is limited to a **"Designated Record Set"** and to the **"Minimum Necessary"** standard, including a **"limited data set,"** as defined in HIPAA and ARRA (as defined in Part 3, below) for these purposes. We may also contact you to provide information about treatment options or alternatives or

other health-related benefits and services that may be of interest to you.

OTHER PERMITTED USES AND DISCLOSURES

• **Disclosure to Others Involved in Your Care:** We may disclose medical information about you to a relative, a friend, or to any other person you identify, provided the information is directly relevant to that person's involvement with your health care or payment for that care. For example, if a family member or caregiver calls us with prior knowledge of a claim and asks us to help verify the status of a claim, we may agree to help them confirm whether or not the claim has been received and paid.

• **Disclosure to Health Plan Sponsor:** Information may be disclosed to another health plan maintained by CITY OF JACKSONVILLE for purposes of facilitating claims payments under that plan. In addition, medical information may be disclosed to CITY OF JACKSONVILLE personnel solely for purposes of administering benefits under the Plans.

• **Workers' Compensation:** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

• **To Comply with Federal and State Requirements:** We will disclose medical information about you when required to do so by federal, state, or local law. For example, we may disclose medical information when required by the U.S. Department of Labor or other government agencies that regulate us; to federal, state, and local law enforcement officials; in response to a judicial order, subpoena, or other lawful process; and to address matters of public interest as required or permitted by law (for example, reporting child abuse and neglect, threats to public health and safety, and for national security reasons). We are also required to disclose medical information about you to the Secretary of the U.S. Department of Health and Human Services if the Secretary is investigating or determining compliance with HIPAA, or to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law. We may disclose your medical information to a health oversight agency for activities authorized by law (such as audits, investigations, inspections, and licensure).

• **To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone who is able to help prevent the threat. For example, we may disclose medical information about you in a proceeding regarding the licensure of a physician.

• **Military and Veterans:** If you are a member of the armed forces, we may release

medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

• **Business Associates:** We may disclose your medical information to our business associates. We have contracted with entities (defined as "business associates" under HIPAA) to help us administer your benefits. We will enter into contracts with these entities requiring them to only use and disclose your health information as we are permitted to do so under HIPAA.

• **Other Uses:** If you are an organ donor, we may release your medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation. We may release your medical information to a coroner or medical examiner. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your information to the correctional institution or law enforcement official.

Uses and disclosures other than those described in this Notice will require your written authorization. Your written authorization is required for: most uses and disclosures of psychotherapy notes; uses and disclosures of PHI for marketing purposes; and disclosures that are a sale of PHI. You may revoke your authorization at any time, but you cannot revoke your authorization if the Plans have already acted on it.

The privacy laws of a particular state or other federal laws might impose a more stringent privacy standard. If these more stringent laws apply and are not superseded by federal preemption rules under the Employee Retirement Income Security Act of 1974 (ERISA), the Plans will comply with the more stringent law.

2. Your Rights Regarding Medical Information About You. You have the following rights regarding medical information that we maintain about you:

• **Right to Inspect and Copy:** You have the right to inspect and obtain a copy of your medical information that may be used to make decisions about your benefits under the Plans. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. If the Plans do not maintain the health information, but know where it is maintained, you will be informed of where to direct your request.

• **Your Right to Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the

Plans.

You also must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend any of the following information:

- Information that is not part of the medical information kept by or for the Plans.
- Information that was not created by us, unless the person or entity that created the information is no longer available to make the amendment.
- Information that is not part of the information which you would be permitted to inspect and copy.
- Information that is accurate and complete.
- **Your Right to an Accounting of Disclosures:** You have the right to request an "accounting of disclosures" (that is, a list of certain disclosures the Plans have made of your health information). Generally, you may receive an accounting of disclosures if the disclosure is required by law, made in connection with public health activities, or in situations similar to those listed above as "Other Permitted Uses and Disclosures". You do not have a right to an accounting of disclosures where such disclosure was made:
- For treatment, payment, or health care operations.
- To you about your own health information.
- Incidental to other permitted disclosures.
- Where authorization was provided.
- To family or friends involved in your care (where disclosure is permitted without authorization).
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances.
- As part of a limited data set where the information disclosed excludes identifying information.

To request this list or accounting of disclosures, you must submit your request, which shall state a time period that is not longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional

lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Notwithstanding the foregoing, you may request an accounting of disclosures of any **"electronic health record"** (that is, an electronic record of health-related information about you that is created, gathered, managed, and consulted by authorized health care clinicians and staff). To do so, however, you must submit your request and state a time period, which may be no longer than three years prior to the date on which the accounting is requested. In the case of any electronic health record created on your behalf on or before January 1, 2009, this paragraph shall apply to disclosures made on or after January 1, 2014. In the case of any electronic health record created on your behalf after January 1, 2009, this paragraph shall apply to disclosures made on or after the later of January 1, 2011, or the date we acquired the electronic health record.

- **Your Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. If the Plans do agree to a request, a restriction may later be terminated by your written request, by agreement between you and the Plans (including orally), or unilaterally by the Plans for health information created or received after the Plans have notified you that they have removed the restrictions and for emergency treatment.

To request restrictions, you must make your request in writing and must tell us the following information:

- What information you want to limit.
- Whether you want to limit our use, disclosure, or both.
- To whom you want the limits to apply (for example, disclosures to your spouse).

Effective February 17, 2010 (or such other date specified as the effective date under applicable law), we will comply with any restriction request if: (1) except as otherwise required by law, the disclosure is to the Plans for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.

- **Right to Request Confidential Communications:** You have the right to request that

we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

You must make any of the requests described above, to the person listed in Part 8, below.

3. Breach Notification. Under changes to HIPAA required by the Health Information Technology for Economic and Clinical Health Act of 2009 and its implementing regulations (collectively, "HITECH Act") under the American Recovery and Reinvestment Act of 2009 ("ARRA"), this Notice also reflects federal breach notification requirements imposed on the Plans in the event that your "unsecured" protected health information (as defined under the HITECH Act) is acquired by an unauthorized party.

We understand that medical information about you and your health is personal and we are committed to protecting your medical information. Furthermore, we will notify you following the discovery of any **"breach"** of your unsecured protected health information as defined in the HITECH Act (the **"Notice of Breach"**). Your Notice of Breach will be in writing and provided via first-class mail, or alternatively, by email if you have previously agreed to receive such notices electronically. If the breach involves:

- 10 or more individuals for whom we have insufficient or out-of-date contact information, then we will provide substitute individual Notice of Breach by either posting the notice on the benefits website on the CITY OF JACKSONVILLE intranet or by providing the notice in major print or broadcast media where the affected individuals likely reside.

- Less than 10 individuals for whom we have insufficient or out-of-date contact information, then we will provide substitute Notice of Breach by an alternative form.

Your Notice of Breach shall be provided without unreasonable delay and in no case later than 60 days following the discovery of a breach and shall include, to the extent possible:

- A description of the breach.

- A description of the types of information that were involved in the breach.

- The steps you should take to protect yourself from potential harm.

- A brief description of what we are doing to investigate the breach, mitigate the harm, and prevent further breaches.

- Our relevant contact information.

Additionally, for any substitute Notice of Breach provided via web posting or major print or broadcast media, the Notice of Breach shall include a toll-free number for you to contact us

to determine if your protected health information was involved in the breach.

4. Changes to This Notice. We can change the terms of this Notice at any time. If we do, the new terms and policies will be effective for all of the medical information we already have about you as well as any information we receive in the future. We will send you a copy of the revised notice.

5. Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Plans or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plans, contact the person listed in Part 8, below. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

6. Other Uses of Medical Information. Other uses and disclosures of medical information that are not covered by this Notice or the laws that apply to us will be made only with your written permission. If you grant us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we may be required to retain our records related to your benefit determinations and enrollment.

7. Effective Date. The effective date of this Notice is January 1, 2023.

8. Contact Information. All correspondence relating to the contents of this Notice should be directed as follows:

Attn: Human Resources Dept.

117 W. Duval St, Suite 150

Jacksonville, FL 32202

(904) 255-8830

Substance Use Disorder Treatment Records (42 CFR Part 2) – Effective 2/16/2026

In certain circumstances, we may receive records relating to the diagnosis, treatment, or referral for treatment of substance use disorder ("**SUD"**) from a federally assisted substance use disorder treatment program that is subject to the confidentiality requirements of 42 C.F.R. Part 2 ("**Part 2 Program"**).

When we receive SUD records that are subject to Part 2, those records continue to receive special privacy protections under federal law. We will use and disclose such records only as permitted by Part 2 and applicable provisions of HIPAA, and only for purposes expressly authorized by law, including treatment, payment, and health care operations, where

permitted.

Federal law provides additional protections for SUD records received from a Part 2 Program. Such records may not be re-disclosed in a manner that would identify an individual as having or having had a substance use disorder, except as permitted by 42 C.F.R. Part 2 or as otherwise authorized by the individual or required by law. We maintain administrative, technical, and physical safeguards to prevent unauthorized use or disclosure of SUD records and to ensure compliance with applicable confidentiality requirements.

Individuals have the right to request access to and obtain copies of their SUD records received from a Part 2 Program, subject to applicable law. Individuals also have the right to request corrections to such records and to receive an accounting of certain disclosures, consistent with HIPAA and 42 C.F.R. Part 2. These rights may be subject to limitations where disclosure is prohibited or restricted by law.

Federal law prohibits discrimination against individuals based on their receipt of substance use disorder treatment. We do not use or disclose SUD records for unlawful or discriminatory purposes, including employment, housing, insurance underwriting, or access to benefits, except as permitted by law.

Individuals may file a written complaint regarding the use or disclosure of SUD records with the U.S. Department of Health and Human Services via mail, email, or online portal, as detailed below:

- **Mail:** Centralized Case Management Operations, U.S. Dept. of HHS, 200 Independence Ave., S.W., Room 509F HHH Bldg., Washington, D.C. 20201
- **Email:** OCRComplaint@hhs.gov
- **OCR Complaint Portal:** https://ocrportal.hhs.gov/ocr/cp/wizard_cp.jsf

Filing a complaint will not result in retaliation or adverse treatment.