Appendix
Summary of Benefits and Coverage
County of St. Johns Board of County Commissioners
Health Reimbursement Arrangement (The "Plan")

For the period from January 1, 2024 through December 31, 2024 (the "Plan Year")

What benefits are you provided under the Plan?

The maximum allowed each year depends on the type of coverage an employee elects. Coverage for "Employee Only" allows for the Plan to reimburse up to $600 of the $1,500 deductible. Coverage for "Employee plus Spouse" allows for the Plan to reimburse up to $1,000 of the $3,000 deductible. Coverage for "Employee plus Child(ren)" allows for the Plan to reimburse up to $1,000 of the $3,000 deductible. Coverage for "Employee plus Family" allows for the Plan to reimburse up to $1,500 of the $3,000 deductible.

However, the maximum reimbursement amount will be prorated for a Participant who is hired in the middle of a Plan Year and begins participating in the Plan in the middle of a Plan Year.

What expenses are considered covered medical care expenses?

For reimbursement, "covered medical care expenses" means expenses incurred by you and/or your covered Spouse and Dependents for "medical care" as defined in Code Section 213(d) and including over-the-counter drugs. Generally, this means an item for which you could have claimed a medical care expense deduction on an itemized federal income tax return (without regard to any threshold limitation or time of payment) for which you have not otherwise been reimbursed or could be reimbursed from insurance or from some other source. For a list of those expenses not covered, please refer to the Summary Plan Description. Those expenses that would be reimbursed by your employer insured group medical Plan, except it is applied to in-network and out-of-network deductible expenses, prescriptions, copayments, and/or coinsurance expenses.

When are covered medical expenses incurred?

For you to be reimbursed for covered medical expenses, you must have incurred them during the Plan Year. An expense is incurred when the service that gives rise to the expense is provided, not when the expense was paid. Note that if you have paid for the expense but if the services have not yet been rendered, then the expense has not been incurred for this purpose. You may not be reimbursed for any expenses arising before you participate or after the close of the Plan Year, or after you terminate, unless you continue coverage under Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA").

Can you continue coverage after termination?

Under COBRA, your employer is required to provide you and/or your covered Spouse and Dependents with the opportunity to be reimbursed for covered medical expenses under the Plan for a limited period of time after termination of your participation in the Plan, unless your

participation was terminated due to gross misconduct. You may be eligible for this continued coverage after certain defined qualifying events have occurred that otherwise would cause you and/or your covered Spouse and Dependents to lose coverage under this Plan.

Please note that such continued coverage will not be offered if you or your covered Spouse or Dependents were not eligible for benefits under the Plan prior to your qualifying event. Please review the Summary Plan Description for the Plan for more details.

What happens if your claim for benefits is denied?

If you have a complaint or are dissatisfied with a denial of coverage for claims under the Plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: Medcom Benefit Solutions at (800) 523-7542 or P.O. Box 10269, Jacksonville, Florida 32247-0269.

When does your participation under the Plan end?

If you terminate employment (including retirement), and do not continue coverage as explained above, your participation under Plan will end the last day of the month in which employment terminated or loss of eligibility occurs.

Does this coverage provide minimum essential coverage?

The Affordable Care Act (the Act) requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan along with the employer's insured group health plan does provide minimum essential coverage.

Does this coverage meet the minimum value standard?

The Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage along with the coverage of the employer's insured health plan does meet the minimum value standard for the benefits it provides.

Where can you receive information regarding coverage under the employer's insured group health plan?

This plan is integrated with your employer's insured group medical plan. For details regarding coverages under that plan, please refer to the Summary of Benefits and Coverage (SBC) for the group medical plan.

Where can you receive additional information regarding the HRA Plan?

If you have questions or need additional information, you may call Medcom Benefit Solutions at (800) 523-7542 or visit www.medcombenefits.com.

