# County of St. Johns Board of County Commissioners
# Health Reimbursement Arrangement

**SUMMARY PLAN DESCRIPTION**

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**502**

Established as of **January 1, 2019**
Amended and Restated as of **January 1, 2024**

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# INTRODUCTION

We are pleased to establish this Health Reimbursement Arrangement to provide you with additional health coverage benefits. The benefits available under this Plan are outlined in this summary plan description. We will also tell you about other important information concerning the Plan, such as the rules you must satisfy before you become eligible and the laws that protect your rights.

Read this summary plan description carefully so that you understand the provisions of our Plan and the benefits you will receive. You should direct any questions you have to the Administrator. There is a plan document on file, which you may review if you desire. In the event there is a conflict between this summary plan description and the Plan document, the Plan document will control.

# I
# GENERAL INFORMATION ABOUT OUR PLAN

This section contains certain general information which you may need to know about the Plan.

## 1. General Plan Information

County of St. Johns Board of County Commissioners Health Reimbursement Arrangement is the name of the Plan.

Your Employer has assigned Plan number 502 to your Plan.

The provisions of your Plan become effective on January 1, 2024. This Plan is a restatement of a Plan which was originally effective January 1, 2019.

This Plan is maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year starts on January 1 and ends on December 31 of each year.

## 2. Employer Information

Your Employer's name, address, and identification number are:

St. Johns County Board of County Commissioners
500 San Sebastian View
St. Augustine, Florida 32804
59-6000825

The Plan allows other employers to adopt its provisions. You or your beneficiaries may examine or obtain a complete list of employers, if any, who have adopted your Plan by making a written request to the Plan Administrator.

 

Other employers who have adopted the provisions of the Plan are:

St. Johns County Property Appraiser
4030 Lewis Speedway, Suite 203
St. Augustine, Florida 32084
59-3285020

St. Johns County Clerk of Courts
4010 Lewis Speedway, Room 171
St. Augustine, Florida 32084
59-6000826

St. Johns County Sheriff's Office
4015 Lewis Speedway,
St. Augustine, Florida 32084
59-6000829

St. Johns County Tax Collector
P.O. Box 9001
St. Augustine, Florida 32085
59-6000831

St. Johns County Supervisor of Elections
4455 Avenue A, #101
St. Augustine, Florida 32095
59-3285020

## 3. Plan Administrator Information

The name, address and business telephone number of your Plan's Administrator are:

St. Johns County Board of County Commissioners
500 San Sebastian View
St. Augustine, Florida 32804
(904) 209-0655

The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Plan Administrator will also answer any questions you may have about our Plan. The Plan Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Plan Administrator are conclusive and binding. You may contact the Plan Administrator for any further information about the Plan.

 

### 4. Claims Administrator Information

The name, address and business telephone number of the claims administrator is:

Medcom Benefit Solutions
P.O. Box 10269
Jacksonville, Florida 32247-0269
800-523-7542

The third party claims administrator is responsible for the actual processing of claims on behalf of the Plan Administrator.

### 5. Service of Legal Process

The Employer is the Plan's agent for service of legal process.

### 6. Type of Administration

The Plan is a health reimbursement arrangement and the administration is provided through a third party claims administrator. The Plan is not funded or insured. Benefits are paid from the general assets of the Employer.

## II
## ELIGIBILITY

### 1. What Are the Eligibility Requirements for Our Plan?

You will be eligible to join the Plan once you have satisfied the conditions for coverage under our group medical plan and enroll.

You will be eligible to join the Plan the first of the month following 30 days after your initial date of employment with the Employer.

### 2. Are There Any Employees Who Are Not Eligible?

Yes, there are certain employees who are not eligible to join the Plan. They are:

- Employees who are not eligible to receive medical benefits under our group medical plan.

- Employees who work, or are expected to work, less than 30 hours a week.

### 3. May I Waive Participation?

In any year, you have the right to waive participation in the Plan.

 

## 4. May I Elect to Suspend or Permanently Opt out of My Account?

You may elect to suspend your account for any future Plan Year by submitting a suspension of benefits form to the Plan Administrator before the beginning of that Plan Year. Your suspension election will remain in effect for the entire Plan Year to which it applies, and you may not modify or revoke the election during that Plan Year.

By electing to suspend your account for a Plan Year, you agree to permanently forgo reimbursements from your account for eligible medical care expenses incurred during that Plan Year, except for certain qualifying dental or vision expenses. Eligible medical care expenses incurred in the Plan Year before the suspended Plan Year may be reimbursed, so long as there was no suspension in effect for that prior Plan Year. You must apply for reimbursement, by submitting an application in writing to the Administrator, no later than 90 days following the close of the Plan Year in which the eligible medical care expense was incurred.

In lieu of a suspension of your account, you may elect to permanently opt out of and waive any right to reimbursements from your account for expenses incurred after the election takes effect, except for limited-scope dental or vision expenses. This opportunity will be offered at least annually by the Plan.

The Employer will not contribute to your account after any suspension of benefits election takes effect or for any Plan Year for which you have suspended your participation in the Plan.

## 5. Are Expenses Reimbursed for Your Spouse and/or Your Dependents?

Yes. Spouses' and Dependents' expenses can be reimbursed. To be reimbursed for a Spouse's or a Dependent's expenses, you must complete and return a new enrollment form. These expenses will be reimbursed after your Spouse or Dependent has qualified, and you have enrolled them to participate.

If you incur a change in family status during the year, as defined under HIPAA, you can change your enrollment form. Generally speaking, changes in family status include, but are not limited to, marriage, divorce, birth or adoption of a child, or death of a Spouse or a Dependent.

Newborn or newly adopted children's expenses are reimbursed as soon as they meet the definition of Dependent, provided that you enroll the child in the Plan within 30 days of the child's birth or placement for adoption.

Coverage for a new Spouse starts on the date you are married provided that you enroll your spouse within 30 days of your marriage.

 

**6. In What Other Situations May You Change Your Enrollment Form During the Year?**

If you declined coverage for yourself, your Spouse, or your eligible Dependents because of other health coverage, in the future you may enroll yourself, your Spouse, and your Dependents in this Plan if you should lose coverage from another plan.

Coverage for your Spouse or Dependents stops when your coverage stops or when you are no longer eligible for coverage subject to the COBRA coverage rules.

Also, if your Spouse or Dependent is an Employee of the Employer, one of you cannot opt out of medical coverage in order to be a Spouse or Dependent in the other's plan. You may only opt out if you are covered by a medical plan outside of the Employer.

**7. Are There Any Other Situations Where You Can Enroll Yourself and Your Dependents in the Plan During the Plan Year?**

Yes. If you and/or your Spouse or eligible Dependents are eligible but did not enroll in the Medical Plan, you and/or your Spouse or eligible Dependents may enroll in the Plan under two additional circumstances, which are:

- Termination of Medicaid or a state child health program coverage resulting from loss of eligibility and you request coverage; or
- Becoming eligible for a premium assistance subsidy in the medical, dental and vision coverage under Medicaid or a state child health program

You must request coverage under the Plan within 60 days of termination or the date it is determined that you or your child are eligible for assistance in order to be entitled to these special enrollment rights.

## III
## BENEFITS

**1. What Benefits Are Available?**

The Plan allows you to be reimbursed for certain out-of-pocket medical, dental, vision and prescription expenses which are incurred by you and your Spouse and Dependents. The expenses which qualify are those permitted by Section 213 of the Internal Revenue Code. These would include over-the-counter drugs. A list of some of the expenses that qualify is available from the Administrator.

The Plan allows you to be reimbursed by the Employer for insurance copayments under our group medical plan which are incurred by you, your Spouse, or your Dependents.

The Plan allows you to be reimbursed by the Employer for any in-network and out of network deductibles which you must meet under our group medical plan which are incurred by you, your Spouse, or your Dependents.

 

The Plan allows you to be reimbursed by the Employer for any coinsurance expenses which you have to meet under our group medical plan which are incurred by you, your Spouse, or your Dependents.

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.

We will provide you with a debit or credit card to use to pay for your medical expenses such as copayments, deductible expenses, medical equipment, prescription drug and insulin costs. The Administrator will provide you with further details.

Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. Any amounts reimbursed to you under the Plan may not be claimed as a deduction on your personal income tax return nor reimbursed by other health plan coverage including our health flexible spending account. You must first use all amounts in our health flexible spending account before submitting any claims to this plan.

You may submit expenses for yourself, your Spouse, and your Dependents.

This plan, as required by WHCRA, will reimburse up to plan limits for benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Contact your Plan Administrator for more information.

**2. When Must Expenses Be Incurred?**

You may submit expenses that you incur each Coverage Period. A new Coverage Period begins each Plan Year. Expenses under this Plan are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged, or you pay for the medical care.

**3. When Will I Receive Payments from the Plan?**

During the course of the Coverage Period, you may submit requests for reimbursement of expenses you have incurred. However, you must make your requests for reimbursements no later than 90 days following the close of the Plan Year. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. In addition, you must submit to the Administrator proof of the expenses you have incurred and that they have not been paid by any other health plan coverage. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement

 

payment soon thereafter. Remember, reimbursements made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes.

**4. What is Coordination of Benefits?**

You, your Spouse, and your Dependents may be covered by other employer sponsored health and welfare plans. If so, benefits from that plan and benefits under the Medical Plan and the Plan are coordinated so they do not pay for the same expenses.

If both you and your Spouse work at the Employer, you cannot both claim each other as a Spouse and submit claims for benefits twice. Only one of you can claim your children as Dependents.

**5. How Does Coordination of Benefits Work?**

If you are covered by two or more plans, one plan is "primary" and the others are "secondary." The primary plan pays benefits first without regard to any other plans. The secondary plans adjust their benefits so that total benefits available will not exceed Allowable Expenses. If the Plan is not primary, you will receive the difference between what the primary plan paid and the total amount of eligible covered expenses. However, neither plan would pay more than it would without the coordination provision.

Coordination of benefits ensures that benefits do not exceed 100% of the reasonable and customary charges for covered expenses. "Covered expenses" are any reasonable and customary charges for health care services for a non-occupational sickness or injury, at least partially covered by at least one of the plans under which you have coverage. If the Plan provides services rather than cash benefits, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid.

**6. Which Plan is Determined to be Primary?**

In general, the Medical Plan covering the patient as an employee will be the primary plan. The primary plan will pay benefits first.

When the patient is an employee in more than one plan, the plan covering the individual for the longer period of time shall be the primary payor.

When the patient is an active employee of one plan and a retiree of another, the plan covering the patient as an active employee shall be primary payor and the plan covering the patient as a retiree is secondary.

If your Dependent child is covered under both you and your Spouse's plan, the plan of the parent whose birthday (month and day only) is earlier in the year will be primary. If you and your Spouse have the same birthday, the plan that has covered the parent for the longest time will be primary. If your Spouse's plan does not have this birth date provision, his or her plan will determine the order of payment for Dependents.

If you are legally separated or divorced, the order of payment for Dependents is:

 

- The plan of the parent with custody of the child.
- The plan of the Spouse of the parent with custody of the child.
- The plan of the parent without custody of the child.

However, if a court decree has given one parent financial responsibility for the child's health care expenses, that plan is primary.

If another plan does not have a coordination provision, it will be the primary plan.

**7. What Information Must be Provided About Your Other Coverage?**

If you, your Spouse, or your Dependents are covered under another plan, you must supply information about that plan to the Claims Administrator in order to receive benefits under this Plan. The Claims Administrator, on behalf of the Employer, has the right to release or obtain any information regarding coverage, expenses, and benefits under any other plan without your consent.

If the benefits you receive from more than one plan exceed your total covered charges, you have been overpaid.

If an overpayment is made under this Plan or Medical Plan because of failure to report other coverage or otherwise, the Claims Administrator on behalf of the Employer, will have the right to recover such overpayment. If payments which should have been made under the Medical Plan or this Plan have been made under other plans, the Claims Administrator on behalf of the Employer, will have the right to reimburse any organizations making such other payments any amounts it considers proper according to the intent of these provisions, and those amounts will be counted for all purposes as benefits paid under this Plan.

**8. Who Makes Benefit Determinations?**

The Employer reserves the exclusive discretionary right to interpret the Plan and make all factual determinations, including matters of eligibility for benefits.

**9. What Rights Does the Employer Have Under the Plan?**

The Employer reserves the right to terminate, modify, amend or change any or all benefit plans at any time and for any reason without the prior consent or agreement of you, your Spouse, or your Dependents. Your participation in the Plan does not guarantee the availability of benefits in the future.

Participants will be notified of any changes through the Employer’s employee publications, including annual enrollment materials and updates to this and other relevant summaries.

 

The Employer and its Plan Administrator have the right to check stated facts, eligibility and benefit amounts. They can adjust benefits and/or make retroactive payroll adjustments if any relevant facts have been misstated.

The Employer recognizes the value of providing benefits for you and the value of the benefits described in this document. However, the benefits described here are not conditions of employment. The language used in this document is not intended to create, nor is it to be construed to constitute, a contract between the Employer and any of its employees for either employment or the provision of any benefit. Employment for employees of the Employer remains at-will.

## 10. What Happens if I Terminate Employment?

If your employment is terminated during the Plan Year for any reason, your participation in the Plan will cease and any unused amounts are forfeited. You will have 90 days following the date of termination to submit claims incurred during and through the last day of the month in which employment terminated. Please see Article V regarding COBRA coverage.

## 11. Family and Medical Leave Act

To the extent that your Employer is subject to FMLA, if you take leave under FMLA, you may revoke or change your existing elections for medical coverage. If your coverage in these benefits terminates, due to your revocation of the benefit while on leave or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return.

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage, you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to “catch up” your payments when you return.

## 12. Uniformed Services Employment and Reemployment Rights Act

If you are going into or returning from military service, you may have special rights to health care coverage under your Health Reimbursement Arrangement under the USERRA. These rights can include extended health care coverage. If you may be affected by this law, ask your Administrator for further details.

## 13. Newborns' and Mothers' Health Protection Act

Group health plans 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 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).

## 14. Qualified Medical Child Support Order

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a participant. The child becomes an "alternate recipient" and can receive benefits under the health plans of the Employer, if the order is determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Plan Administrator.

## 15. End Stage Renal Disease

You are eligible for Medicare if you require regular dialysis or kidney transplant services. Medicare coverage becomes primary and this medical coverage becomes secondary after a 30-month coordination of benefits period (This 30-month period applies if you are already enrolled in Medicare because of age or disability).

## 16. Coverage for Mastectomy

Federal law requires a group health plan to provide coverage for the following services to an individual receiving Plan benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications at all stages of mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

Coverage for breast reconstruction and related services will be subject to deductibles and co-insurance amounts that are consistent with those that apply to other benefits under the Plan.

## 17. The Genetic Information Nondiscrimination Act of 2008

GINA prohibits the Plan from discriminating against individuals on the basis of genetic information.

GINA generally:

- prohibits the Plan from adjusting premium or contribution amounts for a group on the basis of genetic information;
- prohibits the Plan from requesting or mandating that an individual or family member of an individual undergo a genetic test, provided that such prohibition does not limit the authority of a health care professional to request an individual to undergo a genetic test, or preclude a group health plan from obtaining or using the results of a genetic test in making a determination regarding payment;

 

- allows the Plan to request, but not mandate, that a participant or beneficiary undergo a genetic test for research purposes if the Plan does not use the information for underwriting purposes and meets certain disclosure requirements;
- prohibits the Plan from requesting, requiring, or purchasing genetic information for underwriting purposes, or with respect to any individual in advance of or in connection with such individual's enrollment;

### 18. Patient Protection and Affordable Care Act

This Plan does meet all the minimum value requirements of the PPACA. Under PPACA, the plan is considered to be non-grandfathered. This Plan is integrated with the County of St. Johns Board of County Commissioner group health plan.

### 19. Mental Health and Substance Abuse Benefits

MHPAEA imposes significant new requirements on the Plan that offer mental health and substance abuse benefits. Current law prohibits health plans from imposing lower annual and lifetime limits on mental health coverage than on other types of medical coverage. The MHPAEA further limits other types of financial and non-financial limitations that plans may impose on mental health coverage and substance abuse benefits. Some of the MHPAEA's key provisions are as follows:

- financial limitations—including limitations on deductibles, copayments, coinsurance, and out-of pocket expenses—imposed on mental health and substance abuse benefits may not be higher than those imposed on other types of medical coverage;
- the Plan may not place limits on the scope or duration of treatment for mental health or substance abuse that are more restrictive than for other types of medical treatment;
- the Plan must provide, upon request, information to plan participants and providers regarding the criteria for determining whether mental health or substance abuse treatment is medically necessary, and the reasons for denial of coverage; and
- coverage of mental health and substance abuse benefits by out-of-network providers must be on par with out-of-network coverage for medical treatment.

## IV
## ADDITIONAL PLAN INFORMATION

### 1. Participation Following Rehire

If you terminate employment for any reason, including (but not limited to) disability, retirement, layoff or voluntary resignation, and you are then rehired, you must complete the waiting period described in the Eligibility and Participation Requirements before you are again eligible to participate in the Plan.

 

## 2. How to Submit a Claim

When you have a Claim to submit for payment, you must:

(1) Obtain a claim form from the Plan Administrator.

(2) Complete the Employee portion of the form.

(3) Attach copies of all bills from the service provider for which you are requesting reimbursement.

A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

| | |
|---|---|
| Notification of whether Claim is accepted or denied | 30 days |
| Extension due to matters beyond the control of the Plan | 15 days |
| Insufficient information on the Claim: | |
| Notification of | 15 days |
| Response by Participant | 45 days |
| Review of Claim denial | 60 days |

The Claim Administrator will provide written or electronic notification of any Claim denial. The notice will state:

(1) The specific reason or reasons for the denial.

(2) Reference to the specific Plan provisions on which the denial was based.

(3) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(4) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action following a denial on review.

(5) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim; and

 

(6) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the Claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

(1) was relied upon in making the Claim determination;

(2) was submitted, considered, or generated in the course of making the Claim determination, without regard to whether it was relied upon in making the Claim determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that Claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied Claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial Claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

### 3. Right to Seek a Review of a Denied Claim to an External Third Party

You have the right to an external review of the Plan Administrator's denial of your appeal unless the denial was based on your (or your Spouse's or Dependent's) failure to meet the Plan's eligibility requirements.

You must follow the procedures provided by the Plan Administrator to request a review of the denied claim by an external third party the Plan Administrator will provide you with information to what information you must provide to file for the review, deadlines that

 

apply and the third party conducting the review.

Your external appeal must be filed with the external reviewer within 4 months of the date you were served with the Plan Administrator's response to your appeal request. If you do not file your appeal within this 4-month period, you lose your right to appeal. For example, if you received the internal appeal decision on January 3, 2014, you must appeal the decision by May 3, 2014 (or, if that is not a business day, the next business day thereafter).

The external reviewer must notify you and the Plan Administrator of its decision on your external appeal within 45 days after its receipt of your request for external review. The external reviewer's decision is binding upon the parties unless other State or Federal law remedies are available. Such remedies may or may not exist. Therefore, unless another legal right exists under your claim, use of the external review process may terminate your right to bring a lawsuit on your claim.

## V
## COVERAGE RIGHTS UNDER COBRA

Under federal law, COBRA, certain employees and their families covered under this Arrangement will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA coverage") where coverage under the Arrangement would otherwise end. This notice is intended to inform Participants and beneficiaries, in summary fashion, of their rights and obligations under the coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator or its designee is responsible for administering COBRA coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Participants who become qualified beneficiaries under COBRA. The Arrangement itself can provide group health benefits and may also be used to provide health benefits through insurance. Whenever "Arrangement" is used in this section, it means any of the health benefits under this Plan.

### 1. What is COBRA Coverage?

COBRA coverage is the temporary extension of group health plan coverage that must be offered to certain Participants and their eligible family members (called "qualified beneficiaries") at group rates. The right to COBRA coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Arrangement (the "qualifying event"). The coverage must be identical to the coverage that the qualified beneficiary had immediately before the qualifying event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a qualifying event).

### 2. Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation 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 continuation coverage. You can learn more about many of these options at www.healthcare.gov.

### 3. What Other Options May be Available to You When You Lose Medical Coverage Under the Plan?

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

### 4. Who Can Become a Qualified Beneficiary?

In general, a qualified beneficiary can be:

(1) Any individual who, on the day before a qualifying event, is covered under the Arrangement by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a qualified beneficiary is denied or not offered coverage under the Arrangement under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a qualified beneficiary if that individual experiences a qualifying event.

(2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA coverage, and any individual who is covered by the Arrangement as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a qualified beneficiary is denied or not offered coverage under the Arrangement under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a qualified beneficiary if that individual experiences a qualifying event.

The term "covered employee" includes any individual who is provided coverage under the Arrangement due to his or her performance of services for the Employer sponsoring the Arrangement. However, this provision does not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan eligibility provisions.

An individual is not a qualified beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received

 

from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a qualified beneficiary, then a Spouse or Dependent child of the individual will also not be considered a qualified beneficiary by virtue of the relationship to the individual. A domestic partner is not a qualified beneficiary.

Each qualified beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA coverage) must be offered the opportunity to make an independent election to receive COBRA coverage.

**5. What is a Qualifying Event?**

A qualifying event is any of the following if the Arrangement provided that the participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the qualifying event) in the absence of COBRA coverage:

(1) The death of a covered Employee.

(2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan 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 even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(4) A covered Employee's enrollment in any part of the Medicare program.

(5) A Dependent child's ceasing to satisfy the Arrangement's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Arrangement).

If the qualifying event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Arrangement under the same terms and conditions as in effect immediately before the qualifying event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Arrangement occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become qualified beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse or Dependent of the covered Employee, for coverage under the Arrangement that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a qualifying event. A qualifying event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation

 

coverage conditions are present. If a qualifying event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Arrangement provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA coverage even if they failed to pay the Employee portion of premiums for coverage under the Arrangement during the FMLA leave.

**6. What Factors Should Be Considered When Determining to Elect COBRA Coverage?**

You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA coverage may help you avoid such a gap. Second, if you do not elect COBRA coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a qualifying event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA coverage for the maximum time available to you.

**7. What is the Procedure for Obtaining COBRA Coverage?**

The Arrangement has conditioned the availability of COBRA coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

**8. What is the Election Period and How Long Must It Last?**

The election period is the time period within which the qualified beneficiary must elect COBRA coverage under the Arrangement. The election period must begin no later than the date the qualified beneficiary would lose coverage on account of the qualifying event and must not end before the date that is 60 days after the later of the date the qualified beneficiary would lose coverage on account of the qualifying event or the date notice is provided to the qualified beneficiary of her or his right to elect COBRA coverage.

**9. Is a Covered Employee or Qualified Beneficiary Responsible for Informing the Plan Administrator of the Occurrence of a Qualifying Event?**

The Arrangement will offer COBRA coverage to qualified beneficiaries only after the Plan Administrator or its designee has been timely notified that a qualifying event has occurred. The Employer will notify the Plan Administrator or its designee of the qualifying event within 30 days following the date coverage ends when the qualifying event is:

(1) The end of Employment or reduction of hours of Employment,

 

(2) Death of the Employee,

(3) Commencement of a proceeding in bankruptcy with respect to the Employer, or

(4) Enrollment of the Employee in any part of Medicare,

**IMPORTANT:**

**For the other qualifying events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the qualifying event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any Spouse or Dependent child who loses coverage will not be offered the option to elect COBRA coverage. You must send this notice to the Plan Administrator or its designee.**

***NOTICE PROCEDURES:***

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

*County of St. Johns Board of County Commissioner*
*500 San Sebastian View*
*St. Augustine, Florida 32804*
*(904) 209-0655*

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the Employee** covered under the plan,
- the **name(s) and address(es) of the qualified beneficiary(ies)**, and
- the **qualifying event** and the **date** it happened.

If the qualifying event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a qualifying event has occurred, COBRA coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA coverage. Covered Employees may elect COBRA continuation coverage for their Spouses, and

 

parents may elect COBRA coverage on behalf of their children. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that coverage would otherwise have been lost (if under your coverage the COBRA period begins on the date of the qualifying event, even though coverage actually ends later (e.g., at the end of the month) substitute the appropriate language, e.g. "on the date of the qualifying event"). If you or your Spouse or Dependent children do not elect COBRA coverage within the 60-day election period described above, the right to elect COBRA coverage will be lost.

**10. Is a Waiver before the End of the Election Period Effective to End a Qualified Beneficiary's Election Rights?**

If, during the election period, a qualified beneficiary waives COBRA coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

**11. Is COBRA Coverage Available If a Qualified Beneficiary Has Other Group Health Plan Coverage or Medicare?**

Qualified Beneficiaries who are entitled to elect COBRA coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA coverage, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

**12. When May a Qualified Beneficiary's COBRA Coverage Be Terminated?**

During the election period, a qualified beneficiary may waive COBRA coverage. Except for an interruption of coverage in connection with a waiver, COBRA coverage that has been elected for a qualified beneficiary must extend for at least the period beginning on the date of the qualifying event and ending not before the earliest of the following dates:

(1) The last day of the applicable maximum coverage period.

(2) The first day for which Timely Payment is not made to the Arrangement with respect to the qualified beneficiary.

(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

 

(4) The date, after the date of the election, that the qualified beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the qualified beneficiary.

(5) The date, after the date of the election that the qualified beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).

(6) In the case of a qualified beneficiary entitled to a disability extension, the later of:

(a) (i) 29 months after the date of the qualifying event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled qualified beneficiary whose disability resulted in the qualified beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) The end of the maximum coverage period that applies to the qualified beneficiary without regard to the disability extension.

The Arrangement can terminate for cause the coverage of a qualified beneficiary on the same basis that the Arrangement terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a qualified beneficiary and who is receiving coverage under the Arrangement solely because of the individual's relationship to a qualified beneficiary, if the Arrangement's obligation to make COBRA continuation coverage available to the qualified beneficiary ceases, the Arrangement is not obligated to make coverage available to the individual who is not a qualified beneficiary.

## 13. What Are the Maximum Coverage Periods for COBRA Coverage?

The maximum coverage periods are based on the type of the qualifying event and the status of the qualified beneficiary, as shown below.

(1) In the case of a qualifying event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the qualifying event if there is not a disability extension and 29 months after the qualifying event if there is a disability extension.

(2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a qualifying event that is a termination of employment or reduction of hours of employment, the maximum coverage period for qualified beneficiaries other than the covered Employee ends on the later of:

 

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

(b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(3) In the case of a qualified beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA coverage, the maximum coverage period is the maximum coverage period applicable to the qualifying event giving rise to the period of COBRA coverage during which the child was born or placed for adoption.

(4) In the case of any other qualifying event than that described above, the maximum coverage period ends 36 months after the qualifying event.

**14. Under What Circumstances Can the Maximum Coverage Period Be Expanded?**

If a qualifying event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second qualifying event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36-months, but only for individuals who are qualified beneficiaries at the time of and with respect to both qualifying events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36-months after the date of the first qualifying event. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator or its designee and in accordance with the procedures above.

**15. How Does a Qualified Beneficiary Become Entitled to a Disability Extension?**

A disability extension will be granted if an individual (whether or not the covered Employee) who is a qualified beneficiary in connection with the qualifying event that is a termination or reduction of hours of a covered Employee’s employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA coverage. To qualify for the disability extension, the qualified beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice must be sent to the Plan Administrator or its designee and in accordance with the procedures above.

**16. Does the Arrangement Require Payment for COBRA Coverage?**

For any period of COBRA coverage under the Arrangement, qualified beneficiaries who elect COBRA coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA coverage covering a disabled qualified beneficiary due to a disability extension. Your Plan Administrator will inform you of any costs. The Arrangement will terminate a qualified

 

beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

**17. Must the Arrangement Allow Payment for COBRA Coverage to Be Made in Monthly Installments?**

Yes. The health coverage is also permitted to allow for payment at other intervals.

**18. What is Timely Payment for Payment for COBRA Coverage?**

Payment that is made to the Arrangement by a later date is also considered Timely Payment if either under the terms of the Arrangement, covered Employees or qualified beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Arrangement does not require payment for any period of COBRA continuation coverage for a qualified beneficiary earlier than 45 days after the date on which the election of COBRA coverage is made for that qualified beneficiary. Payment is considered made on the date on which it is postmarked to those providing coverage.

If Timely Payment is made to the Arrangement in an amount that is not significantly less than the amount the Arrangement requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Arrangement's requirement for the amount to be paid, unless the Arrangement notifies the qualified beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

**19. Must a Qualified Beneficiary Be Given the Right to Enroll in a Conversion Health Plan at the End of the Maximum Coverage Period for COBRA Continuation Coverage?**

If a qualified beneficiary's COBRA coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Arrangement will, during the 180 day period that ends on that expiration date, provide the qualified beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Arrangement. If such a conversion option is not otherwise generally available, it need not be made available to qualified beneficiaries.

**20. What Other Options May Be Available to You When You Lose Medical Coverage Under the Plan?**

You may be eligible to buy individual medical insurance coverage through the Health

Insurance Marketplace. By enrolling in medical insurance coverage through the Health Insurance Marketplace, you may qualify for a lower cost on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another employer group medical plan for which you are eligible (such as your Spouse's plan), even if that plan generally doesn't accept late enrollees.

## VI
## SUBROGATION AND REIMBURSEMENT

### 1. When will the Plan Ask Me to Repay Benefits Paid to Me?

The purpose of the Plan is to provide you and your Spouse and Dependents with coverage for medical care expenses that are not the responsibility of any third party. If you and/or your covered Spouse and Dependents incur a claim for medical care expenses because of injuries caused by someone else's negligence, wrongful act or omission, the Plan is not responsible to pay these expenses. If this happens, the Plan Administrator or the insurance company will contact you and ask you to sign a subrogation agreement. This means that the Employer or the Insurer can take steps to recover what it paid to cover medical care expenses from the third party that caused injury or illness. If you do not sign a subrogation agreement, your claims for medical care expenses related to the injury or illness may be denied.

### 2. What Rights Does the Plan Have to Recover Expenses It Paid to Me?

The Plan pays your and/or your covered Spouse's and Dependent's claims for medical care expenses, and a third party or entity should pay the claim, you, as the participant, agree to the following conditions:

- The Plan shall be subrogated to all of your and/or your Spouse's and Dependent's rights of recovery arising out of any claim or cause of action which may result or be attributable to a third party's negligent or wrongful acts or omission to the extent of amounts paid.

- You also agree to reimburse the Plan for any medical care expenses paid to you if you recover any amounts from a third party for the injury or illness.

- The Plan's subrogation and reimbursement rights shall apply to any recoveries by you, your covered Spouse and Dependents, or your estate because you (or your covered Spouse or Dependents) suffered an injury or illness that could be attributed to a third party's negligence, wrongful act or omission. The Plan shall have first priority rights and such rights shall extend, but not be limited to, the following recoveries by you:

    - any payment made by or on behalf of a third party, Medical Plan or your insurance company, such as a settlement, judgment, or arbitration award, or otherwise;

 

- any payment as a result of a settlement, judgment, arbitration award or otherwise made by an insurance company for uninsured or underinsured motorist coverage (It doesn't matter whose insurance coverage it is – yours or the other person's);
- any payment from any source that is intended to compensate you or your covered Spouse or Dependents for the injury resulting from the negligence or alleged negligence of a third party;
- any payment under Workers' Compensation;
- any payment under no-fault or other state required motor vehicle insurance;
- any payment made through your automobile, school or homeowner's insurance policy to cover you for the injury.

- You will fully cooperate and do your part to ensure the Plan's right of recovery and subrogation are secured. If necessary, you will grant a lien on any money that you may receive, equal to the value of any amounts paid by the Plan. You will not take any action or be a party to agreement that does not recognize the rights of the Plan to recover expenses. You shall grant a lien on any amounts recovered from a third party and assign it to the Plan for any expenses paid. Similarly, you may not assign rights to any third party to recover money, including your minor children, without the written consent of the Plan Administrator.

- The Plan has a prior lien against all amounts that you may recover, even those amounts designated exclusively for non-medical expense damages. You or your Spouse or Dependents shall not defeat or reduce the Plan's recovery rights by the use of the "Made-Whole Doctrine", "Rimes Doctrine" or any doctrine that is intended to take away the Plan's rights to recover its expenses.

- You may not incur any expenses on behalf of the Plan to pursue a payment. You may not deduct court costs or attorney's fees from any amount reimbursed to the Plan, without written consent from the Plan Administrator. You or your Spouse or Dependents cannot use the "Fund Doctrine", "Common Fund Doctrine" or "Attorney's Fund Doctrine" to use the Plan's funds for these purposes. The benefits under the Plan are secondary to any coverage under no-fault or similar insurance.

- If you and/or your covered Spouse and Dependents fail or refuse to honor the Plan's recovery and subrogation rights, the Plan may recover any costs to enforce its rights. This includes, but is not limited to attorney's fees, litigation, court costs and other expenses.

## VII
## PRIVACY RIGHTS

### 1. What Disclosures of Enrollment/Disenrollment Information are Permitted?

The Plan may disclose to your Employer information on whether you are participating in the Plan, or are enrolled in or have disenrolled. For purposes of this article, PHI means individually identifiable health information that is maintained or transmitted by a covered

entity, subject to specified exclusions as provided in federal regulations. For purposes of this article, Electronic Protected Health Information or Electronic PHI means PHI that is transmitted by or maintained in electronic media.

**2. What Uses and Disclosures of Summary Health Information are Permitted?**

The Plan may disclose Summary Health Information to your Employer, provided your Employer requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (b) modifying, amending, or terminating the Plan.

**3. What Required Uses and Disclosures of PHI are Permitted for Plan Administrative Purposes?**

Unless otherwise permitted by law, and subject to the conditions of disclosure and obtaining written certification, the Plan (or an insurance company on behalf of the Plan) may disclose PHI and Electronic PHI to your Employer, provided your Employer uses or discloses such PHI and Electronic PHI only for Plan administration purposes. "Plan administration purposes" means administration functions performed by your Employer on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by your Employer in connection with any other benefit or benefit plan of your Employer, and they do not include any employment-related functions.

Enrollment and disenrollment functions performed by your Employer are performed on behalf of you and your Spouse and Dependents and are not Plan administration functions. Enrollment and disenrollment information held by the Employer is held in its capacity as the plan sponsor and is not PHI.

Notwithstanding the provisions of this Plan to the contrary, in no event shall your Employer be permitted to use or disclose PHI in a manner that is inconsistent with federal regulations.

**4. Under What Conditions Can PHI Be Disclosed for Plan Administration Purposes?**

Your Employer agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Plan (or an Insurer on behalf of the Plan), your Employer shall:

- not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;
- ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to your Employer with respect to PHI.
- not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of your Employer;

 

- report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for;

- make available PHI to comply with HIPAA's right to access in accordance with federal regulations;

- make available PHI for amendment and incorporate any amendments to PHI in accordance with federal regulations.

- make available the information required to provide an accounting of disclosures in accordance with federal regulations;

- make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;

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

- ensure that the adequate separation between the Plan and your Employer (i.e. the "firewall"), required in federal regulations, is established.

Your Employer further agrees that it creates, receives, maintains or transmits any Electronic PHI (other than enrollment/disenrollment information and Summary Health Information and information disclosed pursuant to a signed authorization that complies with the federal requirements which are not subject to these restrictions) on behalf of the Plan, it will:

- implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives maintains or transmits on behalf of the Plan;

- ensure that the adequate separation between the Plan and your Employer (i.e., the firewall), is supported by reasonable and appropriate security measures;

- ensure that any agent, including a subcontractor, to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and

- report to the Plan any security incident of which it becomes aware, as follows: your Employer will report to the Plan, with such frequency and at such times as agreed, the aggregate number of unsuccessful, unauthorized attempts to access, use, disclose, modify, or destroy Electronic PHI or to interfere with systems operations

 

in an information system containing Electronic PHI; in addition the Employer will report to the Plan as soon as feasible any successful unauthorized access, use disclosure, modification or destruction of Electronic PHI or interference with systems operations in an information system containing Electronic PHI

**5. Who Is Permitted to Disclose Information?**

Your Employer shall allow those classes of employees or other persons in your Employer's control designated by your Employer to be given access to PHI. No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use PHI to the extent necessary to perform the plan administration functions that your Employer performs for the Plan. In the event that any of these specified employees do not comply with the provisions of this section, that employee shall be subject to disciplinary action by your Employer for non-compliance pursuant to your Employer's employee discipline and termination procedures.

Your Employer shall ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the persons designated above create, receive, maintain, or transmit Electronic PHI on behalf of the Plan.

**6. When Can PHI Be Disclosed to Your Employer?**

The Plan shall disclose PHI to your Employer only upon the receipt of a certification by your Employer that the Plan has been amended to incorporate the provisions of federal regulations, and that your Employer agrees to the conditions of disclosure set forth in this summary.

## IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified above. For more information about your rights under 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.

## KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

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

 

## VIII
## GLOSSARY

1. **"ACA"** or PPACA means the Patient Protection and Affordable Care Act of 2010.

2. **"Administrator"** means the Employer or the person or persons designated by the Employer to administer the Plan on behalf of the Employer.

3. **"Adoption Agreement"** means the agreement that the Employer has executed specifying the elective provisions of the Plan and is hereby attached and made part of this Plan.

4. **"Allowable Expense"** means any expense that may be covered by this Plan.

5. **"Claim"** means any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit Claims.

6. **"COBRA"** means the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986, as amended.

7. **"Code"** means the Internal Revenue Code of 1986, as amended.

8. **"Coverage Period"** means the time period as set forth in the Adoption Agreement.

9. **"Dependent"** means any individual who qualifies as a dependent under Code Section 152 (as modified by Code Section 105(b)). Any child of a Participant who is an "alternate recipient" under a qualified medical child support order shall be considered a Dependent under this Arrangement.

   Notwithstanding anything in the Plan to the contrary, a Participant's child may remain on the Plan until the end of the calendar year in which the Dependent attains age 26. A Participant's "child" includes his natural child, and adopted child, or a child placed with the Employee for adoption. It may also include stepchildren, and/or foster children. A Participant's child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end at the end of the calendar year, unless the child qualifies as a Dependent under Code Section 105(b).

   The phrase "placed for adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, and who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

 

10. **"Effective Date"** means the date specified in the Adoption Agreement.

11. **"Eligible Employee"** means any Eligible Employee as elected in the Adoption Agreement and as provided herein. An individual shall not be an "Eligible Employee" if such individual is not reported on the payroll records of the Employer as a common law employee.

12. **"Employee"** means any person who is employed by the Employer. The term "Employee" shall also include any person who is an employee of an Affiliated Employer and any Leased Employee deemed to be an Employee as provided in Code Section 414(n) or (o).

13. **"Employer"** means the entity specified in the Adoption Agreement, any successor which shall maintain this Plan and any predecessor which has maintained this Plan. In addition, unless the context means otherwise, the term "Employer" shall include any Participating Employer which shall adopt this Plan.

14. **"FMLA"** means the Family Medical Leave Act, as referenced under Public Law 103-3 enacted February 5, 1993, and as amended.

15. **"GINA"** means the Genetic Information Nondiscrimination Act of 2008.

16. **"HIPAA"** means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

17. **"Medical Plan"** means a group medical plan sponsored by the Employer or another employer as specified in the Adoption Agreement. It shall be provided in the Adoption Agreement which such plan meets the minimum value requirements as specified under the Patient Protection and Affordable Care Act.

18. **"MHPAEA"** means the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

19. **"Participant"** means any Eligible Employee who has satisfied the requirements of Section 3.1 and has not for any reason become ineligible to participate further in the Plan.

20. **"PHI"** or Protected Health Information means information about an Individual, including genetic information, (whether oral or recorded in any form or medium) that (1) is created or received by the Plan or the Plan Sponsor; (2) relates to the past, present or future physical or mental health or condition of the Individual, the provision of health care to the Individual, or the past, present or future payment for the provision of health care to the Individual; and (3) identifies the Individual or with respect to which there is a reasonable basis to believe the information may be used to identify the Individual. Protected Health Information includes PHI that is transmitted by or maintained in electronic media.

21. **"Plan"** means this Basic Plan Document and the Adoption Agreement as adopted by

 

the Employer, including all amendments thereto. "Plan" means the "Health Reimbursement Arrangement."

22. **"Plan Year"** means each 12-consecutive month period ending on: December 31.

23. **"Spouse"** means an individual as defined under federal law, of a participant, unless legally separated by court decree.

24. **"Summary Health Information"** means information that (a) summarizes the claims history, claims, expenses, or type of claims experienced by individuals for whom your Employer had provided health benefits under the Plan; and (b) from which the identifying information has been deleted, except that the geographic information need only be aggregated to the level of a five-digit zip code.

25. **"WHCRA"** means the Women's Health and Cancer Rights Act of 1998.

 

**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.

 