# CAFETERIA PLAN
# with
# FLEXIBLE SPENDING ARRANGEMENT

# PROVIDED BY

# PINELLAS COUNTY

**Amended and Restated**
**Effective January 1, 2020**

**TABLE OF CONTENTS**


ARTICLE 1. **ESTABLISHMENT AND PURPOSE**

ARTICLE 2. **DEFINITIONS**

ARTICLE 3. **PARTICIPATION**

ARTICLE 4. **PAY CONVERSION AND BENEFIT ELECTIONS**

ARTICLE 4A. **EMPLOYER CONTRIBUTIONS**

ARTICLE 5. **HEALTH PLAN PREMIUMS**

ARTICLE 6. **HEALTH CARE REIMBURSEMENT PLAN**

ARTICLE 7. **DEPENDENT CARE ASSISTANCE PLAN**

ARTICLE 8. **FORFEITURES AND LIMITATIONS**

ARTICLE 9. **CLAIMS REVIEW PROCEDURES**

ARTICLE 10. **PRIVACY AND SECURITY PROVISIONS**

ARTICLE 11. **ADMINISTRATION AND FINANCES**

ARTICLE 12. **AMENDMENTS AND TERMINATION**

ARTICLE 13. **MISCELLANEOUS**

## ARTICLE 1. ESTABLISHMENT AND PURPOSE

**1.1 Establishment**. Pinellas County established this Plan, a section 125/Cafeteria Plan for the benefit of its employees who may participate in the Plan to be effective October 1, 1988. This Plan remains in effect, as amended from time to time, under the terms of the most current amendment.

**1.2 Purpose.** The purpose of the Plan is to provide Employees who may participate in the Plan the choice among different combinations of health, dependent care and other benefits as specified in the Plan. The Plan is established in accordance with the provisions of Section 125 of the Internal Revenue Code and other applicable provisions.

**1.3 Qualified Status.** The Plan is intended to meet the requirements of Section 125 of the Internal Revenue Code and shall be interpreted and administered in accordance with the requirements of that section.

## ARTICLE 2. DEFINITIONS

**2.1 Definitions.** Whenever used in the Plan, the following words and phrases shall have the meanings set forth below unless the context plainly requires a different meaning.

(a) Affiliate means any entity (other than the Employer) that is part of a group of entities that includes the Employer and that constitutes: (i) a controlled group of corporations (as defined in section 414(b) of the Code); (ii) a group of trades or businesses, whether or not incorporated, under common control (as defined in section 414(c) of the Code); or (iii) an affiliated service group (within the meaning of section 414(m) of the Code), and that adopts the Plan with the Employer's consent.

(b) Change in Status, means a Change in Status, as defined in Section 4.2(b)(2) of this Plan.

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

(d) Code means the Internal Revenue Code of 1986, as amended.

(e) Compensation of a Participant means the total of amounts paid to a Participant by the Employer.

(g) Contract Administrator means an administrator that has contracted with the Employer to provide administrative services under the Plan. This term is not the same and is not intended to have the same meaning as the term defined in section 3(16) of ERISA.

(h) Dependent means one of the following individuals:

(1) An individual who qualifies as a dependent under the provisions of Section 152 of the Code.

(2) For purposes of the Health Care Expense Account, the term "Dependent" includes a child who is otherwise a Dependent under this section and who is entitled to coverage under a qualified medical child support order.

(i) Dependent Care Assistance Account means the account established under Section 7.1 for each Participant, as increased under Section 7.2 by allocated Pay Conversion Contributions and as decreased under Section 7.3 by benefit payments made to the Participant.

(j) Effective Date means October 1, 1988 or the date on which the most current amendment takes effect.

(k) Eligible Employee means all employees who works at least 20 hours per week for the Employer continuously for a period of 30 day(s), counting periods that an Employee is on leave required under FMLA or during an absence from work for duty in the uniformed services of the United States of America.

(l) Employee means an Employee of the Employer who receives compensation from the Employer. Employee status shall not be considered to be affected by a leave of absence that is Employer-approved or legally required. However, the term Employee shall not include any person employed by the Employer at a location outside the United States or an individual characterized by the employer as an independent contractor.

(m) Employee Benefit Election Form means the form described in Section 3.2.

(n) Employer means all Appointing Authorities participating in the Unified Personnel System. However, where appropriate, the term Employer shall also mean an Affiliate that is the employer of a particular Participant.

(o) Employment-Related Dependent Care Expense means an amount paid by a Participant for household services or for the care of a Qualifying Individual, to the extent that such expense is incurred to enable the Participant to be gainfully employed for any period for which there are one or more Qualifying Individuals with respect to the Participant and as defined by the Internal Revenue Code or Treasury Regulations as pertains to dependent care FSA. However, (1) if such amounts are paid for expenses incurred outside the Participant's household, they shall constitute Employment-Related Dependent Care Expenses only if incurred for a Qualifying Individual who is a Dependent under the age of 13 for whom the Participant is entitled to an exemption under Section 151 of the Code or for a Qualifying Individual who regularly spends at least eight hours per day in the Participant's household; (2) if the expense is incurred outside the Participant's home at a facility that provides care for more than six individuals who do not regularly reside at the facility, the facility must comply with all applicable licensing requirements, if any; and (3) Employment-Related Dependent Care Expenses of a Participant shall not include expenses paid or incurred for services provided by (i) a child of such Participant who is under the age of 19 or (ii) an individual who is a Dependent of such Participant or such Participant's spouse.

(p) FMLA Leave means a leave of absence provided to an Employee of the Employer under the Family and Medical Leave Act of 1993, as amended.

(q) Health Care Expense means an expense related to the diagnosis, cure, mitigation, treatment, or prevention of disease consisting of expenses for medical care within the meaning of Section 213 of the Code, including, but not limited to, payments for the

purpose of affecting any structure or function of the body, or for any hospital or nursing charges, optometrical, ophthalmological or auditory care, routine physical examinations, well-baby care, dental and orthodontic care, psychiatric care, prescription drugs, insulin, eyeglasses or contact lenses, hearing-aid appliances, similar prosthetic devices, medical-related transportation or medical or dental insurance out-of-pocket expenses.

The term “Health Care Expense” does not include cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease. The term cosmetic surgery means any procedure, which is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

(r) Health Care Expense Account means the account established under Section 6.1 for each Participant, as increased under Section 6.2 by allocated Pay Conversion Contributions and as decreased under Section 6.3 by benefit payments made to the Participant.

(s) Health Savings Account or HSA means a health savings account described in Section 223 of the Code, as designated from time to time by the Employer.

(t) Highly Compensated Employee means a highly compensated individual or participant as defined in Code Section 125(e); a highly compensated employee as defined in Code Section 129(d)(2); or a highly compensated individual as defined in Code Section 105(h)(5).

(u) Group Health Plan means the plan(s) maintained by the employer to provide health benefits including, but not limited to, health, vision, prescription and mental health benefits, to Employer’s Employees.

(v) Key Employee means a key employee as defined in Code Section 416(i)(1).

(w) Participant means a person who is an Eligible Employee on or after the Effective Date, who applies to participate in the Plan, and who satisfies the participation conditions of Article 3.

(x) Pay Conversion Contributions means the contributions of a Participant made by salary reduction agreement in accordance with Section 4.1.

(y) Period of Coverage, with respect to any Plan Year, means that Plan Year. However, for any Employee:

(1) Who becomes a Participant after the start of a Plan Year, the Period of Coverage means the period commencing on the effective date of the Participant's participation and extending through the remainder of the Plan Year, or

(2) Who ceases being a Participant after the start of a Plan Year, the Period of Coverage means the period commencing on the first day of the Plan Year and extending through the last day of the Participant's participation.

(z) Plan means the Pinellas County Section 125 Flexible Benefits Plan as amended or restated from time to time.

(aa) Plan Administrator means the individual designated by the Employer as the party responsible for Administration of this Plan.

(bb) Plan Year means for periods prior to October 1, 2008, the 12-month period beginning October 1 and continuing through September 30; for periods after October 1, 2008, means the period from October 1, 2008 through December 31, 2008; and thereafter means each 12 month period beginning January 1 and continuing through December 31 of each year.

(cc) Premium Only Option means the option to pay group health plan premiums on a pre-tax basis through the Plan.

(dd) Qualifying Individual means (i) a Dependent of a Participant who is under the age of 13, with respect to whom the Participant is entitled to an exemption under Section 151 of the Code, and (ii) a Dependent or spouse of a Participant who is physically or mentally incapable of caring for himself.

**2.2 Gender and Number**. Except as otherwise indicated by context, masculine terminology also includes the feminine, and vice versa, and terms used in the singular may also include the plural.

## ARTICLE 3. PARTICIPATION

**3.1 Participation Conditions**. As a condition of participation and receipt of benefits under this Plan, each Participant shall be required to:

(a) Furnish to the Plan Administrator a completed Employee Benefit Election Form along with required documentation.

(b) Designate and apply a portion of his or her Compensation as Pay Conversion Contributions in accordance with the provisions of Article 4.

(c) Observe all Plan requirements, rules and regulations.

(d) Consent to inquiries by the Plan Administrator with respect to any physician, hospital or other provider of health care or other services involved in a claim under this Plan.

(e) Submit to the Plan Administrator all reports, bills and other information that the Employer may reasonably require.

**3.2 Application to Participate**. As a condition of participation, each Eligible Employee shall complete, sign and deliver to the Plan Administrator an Employee Benefit Election Form before his or her first day of participation. It is by this form that the Eligible Employee applies to participate in the Plan, designates the required portion of his or her Compensation for that Plan Year as Pay Conversion Contributions, makes a benefit election, and supplies any other pertinent information that the Plan Administrator reasonably requires. Unless otherwise required by the Plan Administrator, the application shall be delivered to the Plan Administrator prior to the first day of an Employee's participation. During the annual enrollment period, employees may enroll

online, providing the Employee Benefit Election Form information electronically, in lieu of completing a paper form.

**3.3 Commencement of Participation**. After an Eligible Employee satisfies the participation requirements of this Article 3, the Eligible Employee may become a Participant the latter of:

(a) First of the month following 30 days of employment.

(b) Immediately following the date on which the Plan Administrator receives the Participant's signed Employee Benefit Election Form.

**3.4 Cessation of Participation.** Participation in the Plan will end at the time that an individual ceases to be a Participant as defined in Section 2.1(v). With respect to periods following the date participation otherwise ends, Pay Conversion Contributions will cease but coverage may continue for the remainder of the period of coverage with respect to which the required premium has been paid.

## ARTICLE 4. PAY CONVERSION AND BENEFIT ELECTIONS

**4.1 Pay Conversion.** Each Participant shall designate a portion of his or her Compensation for each Plan year to be applied as Pay Conversion Contributions. The portion shall be specified by the Participant at the time that a benefit election is made under Section 4.2 on the Employee Benefit Election Form or as otherwise directed by the Plan Administrator. The parameters for Pay Conversion are as follows:

(a) The maximum annual contribution per Participant to pay for insurance premiums under Article 5 shall be the actual cost of such premium payments.

(b) The minimum annual contribution per Participant to a Health Care Expense Account under 6.1 shall be $260 and the maximum shall be $2,750.00, or other such maximum set by law.

(c) The minimum annual contribution per Participant to a Dependent Care Assistance Account under Section 7.1 shall be $260.00 and the maximum shall be the lesser of (i) $5,000.00 (with respect to a calendar year), or, instead, $2,500.00 (with respect to a calendar year) if a Participant is married and files a separate Federal income tax return for that year; (ii) the Participant's earned income or (iii) the spouse's earned income, if applicable, or the maximum otherwise allowed by law.

(d) The maximum contribution per Participant to a Health Savings Account is the amount determined for the Participant in accordance with Section 223(b) of the Code, reduced by the amount of any Employer Contribution made to the Participant's HSA under Article 4A.

The Plan Administrator may, if necessary, adjust the rate to account for benefit election adjustments prescribed by Article 5. Except as otherwise provided by the Plan Administrator, Pay Conversion Contributions shall reduce the Participant's Compensation ratably on each pay day beginning on or after the first day of the Participant's participation, and shall continue in effect until changed in accordance with Section 4.2.

### 4.2 Benefit Elections.

(a) Each Participant shall make a benefit election, in the manner provided in the Plan, to apply his or her Pay Conversion Contributions during each Plan Year, in such proportions as he or she chooses, to the following:

(1) To pay the Participant's premiums for Employer-sponsored health care insurance, including medical, pharmacy, vision and EAP/mental health benefits, dental benefits and other insured Employer-sponsored plans, as set forth in Article 5.

(2) To apply to the Participant's Health Care Expense Account for that Plan Year in accordance with Article 6.

(3) To apply to the Participant's Dependent Care Assistance Account for that Plan Year in accordance with Article 7.

(4) With proof of coverage under another plan, to receive cash in lieu of benefits in an amount not to exceed $98.00 per month.

(5) To provide contributions to a Health Savings Account as designated by the Employer.

A Participant's initial benefit election shall be made as part of his or her application to participate under Section 3.2 and the election shall remain in effect until changed in accordance with this Section. A Participant may change her benefit election for a subsequent Plan Year by providing written notice to the Plan Administrator on a new Employee Benefit Election Form prior to the first day of the Plan Year for which such change is to be effective.

(b) A Participant's benefit election for any Plan Year shall be irrevocable during the Plan Year, except that:

(1) The Plan Administrator may limit a Participant's contributions in accordance with Section 8.2.

(2) Change in Status

(A) If the Participant has a Change in Status (as defined in Subsection (B) below), he shall be entitled to revoke or modify his benefit election in a manner that is consistent with such Change in Status (as defined in Subsection (C) below), by providing written notice to the Plan Administrator within 31 days of the status change. An authorized change in the Participant's benefit election due to a Change in Status shall be effective the latter of:

(i) First of the month following the date the Change in Status occurs.

(ii) Immediately following the date on which the Plan Administrator receives the Participant's written notice.

(B) A Change in Status is an event that falls into one of the following categories:

(i) Legal Marital Status changes: including marriage, death of spouse, divorce, legal separation and annulment.

(ii) Changes in Number of Dependents: including birth, death, adoption or placement for adoption.

(iii) Employment Status changes of the Participant or the Participant’s spouse or dependents: termination or commencement of employment, strike or lockout, commencement or return from unpaid leave of absence, change of work-site or change in employment status.

(iv) Dependent Satisfies or Ceases to Satisfy the Requirements for Unmarried Dependents: change in student status or dependent no longer qualifies because of age.

(v) Change in Residence: change in place of residence of the employee, spouse or dependent.

(C) For accident or health coverage, the election change is consistent with the Change in Status only if the election change is on account of and corresponds with a change in status that affects eligibility for coverage under an employer’s plan.

For other qualified benefits, the election change is consistent with the Change in Status only if it meets one of the following conditions:

(i) The election change is on account of and corresponds with a change in status that affects eligibility for coverage under an employer’s plan.

(ii) The election change is on account of and corresponds with a change in status that affects expenses described in IRC Section 129 with respect to the Dependent Care Assistance Account.

The consistency rule of this Subsection shall be interpreted in accordance with the Special Consistency rules of applicable law.

(3) Special Events

(A) A Participant may revoke or modify a benefit election during the current Plan Year if the revocation or modification is on account of: (i) a Qualified Medical Child Support Order (QMCSO) or other Judgments or

Orders under 29 USC Section 1169(a); (ii) the special enrollment rights of the Health Insurance Portability and Accountability Act of 1996 (HIPAA); (iii) an employee, spouse or dependent becomes entitled to coverage under Part A or Part B of Medicare or Medicaid or on account of a COBRA Qualifying Event; (iv) coverage of the Participant or of his or her Dependent under Medicare or under the Children's Health Insurance Program (CHIP) terminates due to loss of eligibility; or (v) the Participant or his or her Dependent becomes eligible for a CHIP premium assistance subsidy. In the case of an event described in clause (iv) or (v), the Participant shall have 60 days from the date of the event in which to make an election.

(B) A Participant, on account of an unpaid FMLA Leave, may revoke a benefit election. When the Participant returns from unpaid FMLA Leave after having revoked their benefit election on account of taking FMLA Leave, they may have their benefit election reinstated on the same terms as prior to taking FMLA Leave, to the extent that reinstatement is required under the FMLA. A reinstated Participant shall not have a greater right to benefits for the remainder of the Plan Year than a Participant who is continuously working during the Plan Year.

(4) **Cost/Coverage Changes**

(A) Cost Changes

(i) The Employer may modify a Participant's contribution in accordance with the automatic adjustment in Section 5.2.

(ii) If the cost of coverage of an Employer-sponsored Plan described in Section 5.1 significantly increases, a Participant who is covered under that Employer-sponsored Plan may choose to pay the increased premium or revoke coverage under the plan for which the premiums are being increased and elect coverage under a plan providing similar coverage, if available.

(iii) With respect to a Dependent Care Assistance Plan under Article 7, a Participant may modify a benefit election if the cost for service provided by a dependent care provider, who is not a relative of the Participant, increases or decreases.

(B) Coverage Changes

(i) If coverage provided under a plan described in Section 5.1 or Article 7 is significantly curtailed or ceased, a Participant who is covered under that plan shall be entitled to change a benefit election by revoking coverage under the plan being curtailed or ceased and elect coverage under a plan providing similar coverage, if available.

(ii) If during a period of coverage, a new benefit plan is added (or eliminates an existing plan), a Participant may elect the new benefit plan (or elect another benefit plan if an option has been eliminated) and make a corresponding election change with respect to other plans providing similar coverage.

(iii) A Participant may make a change in such Participant's benefit election if such change is on account of and corresponds with a change made under the plan of the Participant's spouse, former spouse or dependent and either (a) such change is permitted under the cafeteria plan (or qualified benefit plan) of such spouse, former spouse or dependent and Code requirements applicable to such change; or (b) this Plan permits participants to make an election for a period of coverage which is different from the period of coverage under the cafeteria plan (or qualified benefit plan) of the spouse, former spouse or dependent.

(C) This Section 4.2(b)(4) does not apply to an election change with respect to the Health Care Reimbursement Plan described in Article 6.

(5) A Participant who separates from the service of the Employer during a period of coverage may revoke existing benefit elections and terminate the receipt of benefits for the remaining portion of the period of coverage. If the Employee should return to service within 30 days for the Employer during the same plan year, the Employee shall reenroll with the same benefit elections prior to termination for the remaining portion of the period of coverage. If the Employee should return to service of the Employer after 30 days, but during the same plan year, the Employee may re-enroll with a new benefit election for the remaining portion of the period of coverage.

(6) Notwithstanding the provisions of this Section 4.2, a Participant may prospectively make, revoke or change an election with respect to Health Savings Account contributions at any time.

(7) Mid year elections may be made as otherwise permitted by law if such elections are adopted or allowed by the Plan Administrator.

**4.3 Contribution during Leave.** With respect to Participants who go on a leave of absence which is Employer-approved or unpaid FMLA Leave, contributions required or permitted to be made by them under the Plan may be made by one of the following methods, which must be nondiscriminatory, as agreed between the Employee on leave and the Plan Administrator before the commencement of the leave of absence or the applicable coverage period:

(a) Contributions may be made by the Employee on leave on a regular basis (generally on an after-tax basis).

(b) Contributions may be made by the Employee on leave by pre-payment (generally on a pre-tax basis with respect to the same Plan Year during which the leave occurs).

(c) Contributions advanced by the Employer on behalf of an Employee on leave may be re-paid by the Participant when he or she returns from leave on either a pre-tax with respect to the same Plan Year during which the leave occurs or on an after-tax basis.

## ARTICLE 4A. EMPLOYER CONTRIBUTIONS

**4A.1 Eligibility for Employer Contributions**. For each Plan Year, in addition to Pay Conversion Contributions described in Article 4, the Employer may make a contribution to the HSA of each Participant who has elected coverage under a High-Deductible Health Plan and has established a HSA, as described in this Article 4A. Employer Contributions may be made on behalf of Participants, whether or not such Participants also elect to make Pay Conversion Contributions to HSAs, provided that each such Participant has had the opportunity to have a Pay Conversion Contribution made and applied as described in Section 4.2(a)(5).

**4A.2 Amount of Employer Contribution**. The amount, if any, that will be contributed by the Employer for a Plan Year, the timing of the contribution and the method by which the contribution is made (i.e., single payments or periodic installments throughout the Plan Year) shall be determined by the Employer in its sole discretion, and may vary from year to year. The contribution for a Plan Year need not be identical among Participants, provided that differences in the amounts contributed (including whether a contribution is made at all for a Participant) shall be based upon factors other than individual selection of Participants.

**4A.3 Treatment of Employer Contributions**. Employer Contributions made hereunder shall constitute contributions made through a cafeteria plan, for purposes of the Code and the excise tax regulations, and the provisions of this Plan shall be construed, if necessary, in the manner required for the contributions to be so treated.

## ARTICLE 5. HEALTH PLAN PREMIUMS

**5.1 Coverages.** To the extent a Participant so elects, a portion of the Participant's Pay Conversion Contributions shall be used to pay the Participant's share of the cost of coverage (single or family coverage, whichever applies) under the following Employer-sponsored Plans:

(i) Pinellas County Group Health Plan

(ii) Pinellas County Group Dental Plan

The benefit description in each of those plans is incorporated by reference into this Plan. The terms and conditions of each of those plans shall govern the provision of benefits under each plan.

**5.2 Automatic Adjustments.** If during the Plan Year the cost of Employer-sponsored Plans described in Section 5.1 which is selected by a Participant changes and the change is not significant, the Participant's benefit election shall, with respect to premium payments for that health plan, automatically be adjusted to reflect such change. A Participant shall not be permitted to change coverage during a Plan Year because of change in the cost of coverage, except as otherwise provided in Article 4.

## ARTICLE 6. HEALTH CARE REIMBURSEMENT PLAN

**6.1 Health Care Expense Accounts.** The Plan Administrator shall establish for each Participant who elects the benefit option under this Article 6 a Health Care Expense Account for each Plan Year.

**6.2 Increases in Health Care Expense Account.** A Participant's Health Care Expense Account for a Plan Year shall be increased by the portion of the Participant's Pay Conversion Contributions for that Plan Year that he has elected to apply toward his Health Care Expense Account in accordance with Section 4.2.

**6.3 Decreases in Health Care Expense Account.** The balance in a Participant's Health Care Expense Account for a Plan Year shall be reduced by the amount of any benefits paid to a Participant under Section 6.4.

**6.4 Health Care Benefits.** Subject to limitations contained in other provisions of this Plan, a Participant who elects the benefit option under this Article 6 and who incurs Health Care Expenses attributable to himself, his spouse or his dependents during his Period of Coverage for a Plan Year shall be entitled to receive from the Plan full reimbursement for the entire amount of such expenses to the extent of the amount of the Participant's benefit election for the Health Care Expense Account for that Plan Year.

**6.5 Reimbursement Procedures.** In order to receive reimbursement for health care expenses under this Article 6:

(a) (i) The Participant must complete a Claim Form, attach an itemized billing statement from the health care provider, an explanation of benefits from the Participant's insurer or other satisfactory proof of claim, and forward the documents to the Administrator. The Participant must provide additional information reasonably requested by the Administrator.

(ii) Health care expenses may be paid at the Point of Service with the FSA debit card. Receipts must be retained to substantiate a qualified expense.

(b) A request for reimbursement must relate to Health Care Expenses incurred during the Participant's period of coverage. For this purpose, the term "incurred" refers to when the health care services were provided. In no event may claims incurred in one plan year be submitted during the following Plan Year, nor shall any unpaid claims be the liability of the Plan, the Employer, or the Administrator.

(c) A request for reimbursement for Health Care Expenses incurred during a Plan Year must be received by the Administrator either during the Period of Coverage or on or before 90 days following the Period of Coverage.

(d) Reimbursement, if made, shall be made by the Administrator directly to the Participant, upon which the Employer, the Plan, and the Administrator shall be relieved of all further responsibility with respect to the expenses reimbursed.

Upon presentation of a claim, a Participant shall expressly represent that the item for which a claim is made is not subject to reimbursement under any policy described in Article 5 or from any other source and such item will not be used as a deduction under Section 213 of the Code.

(e) The Employer may establish a minimum reimbursement amount.

**6.6 Limitations on Health Care Benefits.** Despite the provisions of this Article 6, no benefits shall be paid under this Article:

(a) If and to the extent that such reimbursement or payment is covered under any insurance policy or policies, whether paid for by the Employer or the Participant, or under any other health and accident plan by whoever maintained. In the event that there is such a policy or plan in effect providing for such reimbursement or payment, in whole or in part, then to the extent of the coverage under such policy or plan, the Employer and the Plan shall be relieved of any liability.

(b) To the extent that an expense has been submitted for reimbursement from a Participant's Dependent Care Assistance account.

(c) For any expenses incurred for medical insurance premiums.

**6.7 Limited Purpose Health Care Reimbursement Account**. A Participant who participates in a High-Deductible Health Plan and contributes or receives contributions to a HSA as described in Section 4.1(a) and Section 4A.1 may only participate in a limited purpose Health Care Reimbursement Account. Funds in the limited purpose Health Care Reimbursement Account can only be used for dental and vision expenses not covered by the Participant’s High-Deductible Heath Plan. The same procedures for reimbursement and maximum annual contribution limits that apply to the Health Care Reimbursement Account apply to the Limited Purpose Health Care Reimbursement Account.

**6.8 Continuation of Health Care Coverage.** To the extent required by COBRA, a qualified beneficiary who would lose Health Care coverage under the Plan upon the occurrence of a qualifying event shall be permitted to continue Health Care coverage under the Plan by electing to pay the applicable premiums, on an after-tax basis, in accordance with procedures established by the Plan Administrator and as may be required by law. The Employer shall provide notice to each covered Employee and spouse of their rights under COBRA in accordance with applicable law and the regulations thereunder.

**6.9 Additional Requirements for Group Health Plans.** The Health Care Reimbursement Plan shall be interpreted and administered so as to provide coverage, under written procedures established by the Administrator, with respect to individuals for which coverage is required by the applicable provisions of ERISA section 609 and any regulations under those provisions.

**6.10 Separate Written Plan.** For purposes of the Code, this Article shall constitute a separate written plan providing for the reimbursement of Health Care Expenses. To the extent necessary, other provisions of the Plan are deemed incorporated by reference in this Article 6.

## ARTICLE 7. DEPENDENT CARE ASSISTANCE PLAN

**7.1 Dependent Care Assistance Account.** The Plan Administrator shall establish for each Participant who elects the benefit option under this Article 7, a Dependent Care Assistance Account for each Plan Year. Each Dependent Care Assistance Account shall contain zero dollars ($0.00) initially and at the commencement of each Plan Year.

**7.2 Increases in Dependent Care Assistance Account.** A Participant's Dependent Care Assistance Account for a Plan Year shall be increased each payroll period by the portion of the Participant's Pay Conversion Contributions for that Plan Year that he has elected to apply toward his Dependent Care Assistance Account in accordance with Section 4.2.

**7.3 Decreases in Dependent Care Assistance Account.** The balance in a Participant's Dependent Care Assistance Account for a Plan Year shall be reduced by the amount of any benefit paid to or on behalf of a Participant under Section 7.4.

**7.4 Dependent Care Benefits.** Subject to limitations contained in other provisions of this Plan, a Participant who elects the benefit option under this Article 7 and incurs Employment-Related Dependent Care Expenses during his Period of Coverage for a Plan Year shall be entitled to receive from the Plan full reimbursement for the entire amount of such expenses to the extent of the amount contained in the Participant's Dependent Care Assistance Account for that Plan Year. However, no reimbursement shall be paid pursuant to this Article to the extent that an expense has been submitted for reimbursement from a Participant's Health Care Expense Account.

**7.5 Reimbursement Procedures.** In order to receive reimbursement for dependent care expenses under this Article 7:

(a) The Participant must complete a Claim Form, attach a statement of service from the dependent care provider or other proof of claim, and forward the documents to the Administrator. The Participant must provide additional information reasonably requested by the Administrator.

(b) A request for reimbursement that exceeds the balance in the Participant's Dependent Care Assistance Account shall be processed only to the extent of the amount of the account balance. The excess shall be carried over to the following reimbursement period and processed at that time. However, after the Participant's Dependent Care Assistance Account has been exhausted, claims remaining unpaid at the end of the Plan Year shall be canceled. In no event may these claims be resubmitted during the following Plan Year, nor shall any unpaid claims be the liability of the Plan, the Employer, or the Administrator.

(c) A request for reimbursement must relate to Employment-Related Dependent Care Expenses incurred during the Participant's Period of Coverage. For this purpose, the term “incurred” refers to when the dependent care services were provided.

(d) A request for reimbursement for Dependent Care Expenses incurred during a Plan Year must be received by the Administrator either during the Period of Coverage or on or before 90 days following the Period of Coverage.

(e) Reimbursement, if made, shall be made by the Administrator directly to the Participant, which shall cause the Employer, the Plan, and the Administrator to be relieved of all further responsibility with respect to the expense reimbursed.

(f) The Employer may establish a minimum reimbursement amount.

**7.6 Separate Written Plan.** For purposes of the Code, this Article shall constitute a separate written plan providing a program for the reimbursement of dependent care assistance expenses. To the extent necessary, other provisions of the Plan are deemed incorporated by reference in this Article 7.

## ARTICLE 8. <u>FORFEITURES AND LIMITATIONS</u>

**8.1 Account Forfeitures.** Any amounts contributed to a Participant's Health Care Expense Account or Dependent Care Assistant Account which have not been used to pay claims for benefits incurred by the end of each period of coverage after the period for filing claims has expired shall be forfeited by a participant, except that the maximum amount allowed by law of unused amounts contributed to a Participants Health Care Expense Account shall be carried over to the subsequent Plan Year.

**8.2 Limitation on Contributions and Benefits for Certain Participants.** The Plan Administrator shall determine, before or during any Plan Year, whether the Plan fails to satisfy for the Plan Year any nondiscrimination requirement imposed by the Code, or any limitation on benefits provided to Employees who are considered Highly Compensated Employees, Key Employees and/or 5% owners under applicable Code provisions. The Plan Administrator shall take action that it deems appropriate, under rules uniformly applied to similarly situated Participants, to assure compliance with such requirements or limitations. Such action may include, without limitation, a modification of elections by Highly Compensated Employees, Key Employees and/or 5% owners with or without the consent of such Employees.

**8.3 Opt Out.** Any Health Care Expense Account participant shall have the right to opt out of the carryover if such participant has already enrolled in a health care savings account for the following Plan Year.

## ARTICLE 9. <u>CLAIMS REVIEW PROCEDURES</u>

**9.1 Determinations.** The Contract Administrator shall notify a Participant in writing within 30 days of his written application for benefits of his eligibility or non-eligibility for benefits under the Plan unless special circumstances require an extension of time for perfecting the claim. Notice must be given to the claimant of the extension within 30 days of his submission of the claim. The notice must specify the reason for the extension of the date with which a decision is expected to be rendered.

**9.2 Notice.** If the Contract Administrator determines that a Participant is not eligible for all or part of the benefits, the notice shall set forth (a) the specific reasons for such denial, (b) a specific reference to the provision of the Plan on which the denial is based, (c) a description of any additional information or material necessary for the claimant to perfect his claim and a description of why it is needed, and (d) an explanation of the Plan's claims review procedure and other appropriate information as to the steps to be taken in the event the participant wishes to submit the denied claim for review.

**9.3 Review.** If a Participant is determined by the Contract Administrator to be ineligible for benefits, or if the Participant believes that he is entitled to greater or different benefits, he shall have the opportunity to have his denied claim reviewed by the Contract Administrator by filing a petition for review with the Contract Administrator within 60 days after he received the claim denial notice. The petition shall state the specific reasons, which the Participant believes, entitle him to benefits or to greater or different benefits. Within 60 days after the Contract Administrator receives the petition for review, the Contract Administrator shall afford the Participant (and his counsel, if any) an opportunity to present his position to the Contract Administrator orally or in writing, and the Participant (or his counsel) shall have the right to review the pertinent documents.

**9.4 Decision.** The Contract Administrator shall notify the Participant of its final decision in writing within the 60-day period after receiving the request for review stating specifically in writing the basis of the decision in a manner calculated to be understood by the Participant and the specific provisions of the Plan on which the decision is based. If, due to special circumstances (such as the need for a hearing), the 60-day period is not sufficient, the final decision may be deferred for up to another 60-day period at the election of the Contract Administrator and notice of this deferral shall be given to the Participant prior to the commencement of the extension. If a Participant dies, the same procedure shall apply to his beneficiaries.

## ARTICLE 10. PRIVACY AND SECURITY PROVISIONS

**10.1 Providing Protected Health Information to Plan Sponsor.**

(a) Disclosing Protected Health Information to Designated Classes of Employees of the Plan Sponsor. The Plan shall disclose Protected Health Information to designated classes of employees of the Plan Sponsor only upon the receipt of a certification of the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in paragraph 4 of this Section.

(b) Adequate Separation Between Plan and Plan Sponsor. The Plan will disclose Protected Health Information only to employees of the Unified Personnel System needing access to protected health information relating to payment of claims, health care operations or other plan functions. These employees only shall have access to and use Protected Health Information to the extent necessary to perform the Plan Administration Function that the Plan Sponsor 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 the Plan Sponsor for non-compliance pursuant to the Plan Sponsor's employee discipline and termination procedures.

**10.2 Conditions of Disclosure.** The Plan Sponsor agrees that with respect to any Protected Health Information disclosed to it by the Plan, Plan Sponsor shall:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan or as required by law.

(b) Ensure that any agents, including a subcontractor, to whom it provides Protected Health Information received from the Plan agree to the same restrictions and

conditions that apply to the Plan Sponsor with respect to Protected Health Information.

(c) Not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

(d) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.

(e) Make available Protected Health Information in accordance with 45 CFR §164.524.

(f) Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 CFR §164.526.

(g) Make available the information required to provide an accounting of disclosure in accordance with 45 CFR §164.528.

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with subpart E of 45 CFR §164.

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Plan Sponsor 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 of the information is infeasible, the Plan Sponsor shall maintain the information only for the purpose that makes return or destruction infeasible.

(j) Ensure that the adequate separation between Plan and Plan Sponsor, required in 45 CFR §504(f)2)(iii), is satisfied, and that such separation is supported by reasonable and appropriate security measures.

(k) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the covered entity.

(l) Ensure that any agent, including a subcontractor, to whom it provides Protected Health Information agrees to implement reasonable and appropriate safeguards to protect it.

(m) Report to the Plan any security incident of which it becomes aware.

**10.3 Definitions.**

(a) Covered Entity means (i) a Health Plan, (ii) a health care clearinghouse, or (iii) a health care provider who transmits any Health Information in electronic form in connection with a Transaction.

(b) Electronic PHI is PHI that is maintained in or transmitted by electronic media. Electronic storage media includes memory devices in computers (hard drives), removable/ transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card. Electronic transmission media include any

media used to exchange information already in electronic storage media, such as the Internet (wide-open), extranet (using Internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and physically moving removable/ transportable electronic storage media. Fax machines and telephones are not considered electronic transmission media unless they transmit information stored in an electronic format (i.e. faxes that send information directly to a computer or from a computer, or telephones that send information via the internet).

(c) Health Information means any information, whether oral or recorded in any form or medium that (i) is created or received by a health care provider, Health Plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (ii) relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual.

(d) Health Plan means any individual or group plan that provides or pays the cost of medical care (as defined in Section 28\79(1)(2) of the PHS Act, 42 U.S.C. §300gg-91(a)(2).

(e) Individually Identifiable Health Information means a subset of Health Information, including demographic information collected from an individual, and (i) is created or received by a health care provider, Health Plan, employer or health care clearinghouse; and (ii) relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (iii) either identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

(f) Plan Administration Function means administration functions performed by the Plan Sponsor on behalf of the Plan, excluding functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor.

(g) Protected Health Information means Individually Identifiable Health Information that is (i) transmitted by electronic media; (ii) maintained in any media described in the definition of electronic media at 42 CFR §16.103; or (iii) transmitted or maintained in any other form or medium. Notwithstanding the preceding, Protected Health Information does not include Individually Identifiable Health Information in (i) education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. §1232g; (ii) records described at 20 U.S.C. §1232g(a)(4)(B)(iv); and (iii) employment records held by a Covered Entity in its role as employer.

(h) Summary Health Information means information that (i) summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a Health Plan; and (ii) from which the information described at 42 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR §164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.

(i) Transaction means the transmission of information between two parties to carry out financial or administrative activities related to health care.

## ARTICLE 11. ADMINISTRATION AND FINANCES

**11.1 Administration.** The Plan shall be administered by the Plan Administrator referred to in Section 2.1(z).

**11.2 Finances.** The administrative costs of the Plan shall be borne by Pinellas County. For purposes of this Plan, Pay Conversion Contributions shall be deemed to be contributions by the Employer.

## ARTICLE 12. AMENDMENTS AND TERMINATION

**12.1 Amendments.** The Pinellas County Board of County Commissioners may amend the Plan, in full or in part, at any time. Any amendment shall be timely filed with the Plan documents and reasonable notification provided to Employees.

**12.2 Benefits Provided Through Third Parties.** In the case of any benefit provided pursuant to any insurance policy or other contract with a third party, the Pinellas County Board of County Commissioners may amend the Plan by changing insurers, policies or contracts without changing the language of this Plan document, provided that copies of the contracts or policies are filed with the Plan documents and the Participants are reasonably informed (to the extent required by law) as to the effects of any such changes. If there is any perceived conflict or inconsistency at any given point in time among the description of benefits contained in the contract or policy and the other Plan documents, the terms of the contract or policy shall control.

**12.3 Termination.** The Pinellas County Board of County Commissioners intends the Plan to be permanent, but necessarily must, and does, reserve the right to terminate the Plan at any time. In the event of a Plan termination, Pay Conversion Contributions will cease. Thereafter neither the Employer nor any of its Employees shall have any further financial obligations under the Plan except such that have accrued up to the date of termination and have not been satisfied.

## ARTICLE 13. MISCELLANEOUS

**13.1 No Guaranty of Employment.** The adoption and maintenance of the Plan shall not be deemed to be a contract of employment between the Employer and any Employee. Nothing contained in the Plan shall give any Employee the right to be retained in the employ of the Employer or to interfere with the right of the Employer to discharge any Employee at any time, nor shall it give the Employer the right to require any Employee to remain in its employ or to interfere with the Employee's right to terminate his employment at any time.

**13.2 Limitation on Liability.** The Employer does not guarantee benefits payable under any group health plan.

**13.3 Non-Alienation.** No benefit payable at any time under this Plan shall be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment, or encumbrance of any kind.

**13.4 Exclusive Benefit.** The Plan shall be maintained for the exclusive benefit of Employees. Benefits shall be paid only in accordance with the Plan's terms. Reasonable expenses of administering the Plan may be paid only in accordance with the Plan's terms.

**13.5 Applicable Law.** The Plan and all rights under the Plan shall be governed by and construed according to the laws of the State of Florida**,** except to the extent preempted by Federal Law.

IN WITNESS WHEREOF, the Employer has caused this Plan to be executed on this _____ day of _____________________, 2020.

| ATTEST:<br>KEN BURKE, CLERK OF COURT | PINELLAS COUNTY, FLORIDA<br>By and through its Board of County Commissioners |
|---|---|
| By:__________________________________<br>Deputy Clerk | ____________________________________<br>Chairman |

APPROVED AS TO FORM
OFFICE OF COUNTY ATTORNEY

By:_____________________________
Senior Assistant County Attorney

Prolaw Doc. # 292300