Plan Document and
Summary Plan Description for the
Jacksonville Police Officers and Fire Fighters Health Insurance Trust Health and Welfare Benefit Plan

EFFECTIVE DATE: 01/01/2020

Introduction

Jacksonville Police Officers and Fire Fighters Health Insurance Trust (the "Trust") is pleased to offer benefits through the Jacksonville Police Officers and Fire Fighters' Health Insurance Trust Health and Welfare Benefit Plan. These benefits are a valuable and important part of your overall compensation package with the City of Jacksonville (the "Employer").

This booklet provides important information about the Benefit Program(s) covered under the Plan. It serves as the Plan document and the Summary Plan Description ("SPD") for the Jacksonville Police Officers and Fire Fighters' Health Insurance Trust Health and Welfare Benefit Plan ("the Plan").

The "Benefit Programs" covered by this Plan are shown in Appendix A. For fully insured Benefit Programs, the insurance contracts or policies (including amendments and riders), plan descriptions, benefit summaries, schedule of benefits and other descriptive documents relating to each Benefit Program (collectively, the "insurance certificates") are incorporated herein by reference only to the extent they are the source of eligibility, benefits, claims procedures, or other substantive provisions of the Benefit Programs. This booklet is not intended to give any substantive rights to benefits that are not already provided by the insurance certificate for an insured benefit. If the terms of this booklet conflict with the substantive terms of an insurance certificate for an insured Benefit Program, the terms of the insurance certificate will control, unless otherwise required by law.

This Plan document/SPD replaces all previous booklets you may have in your files. Be sure to keep this booklet in a safe and convenient place for future reference. We encourage you to read this booklet and insurance certificates and become familiar with your benefits. You may also wish to share this information with your enrolled family members.

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Plan Overview

The Plan provides benefits to eligible employees and their dependents through each Benefit Program listed in Appendix A. Fully insured benefits are payable solely by the Insurer listed for the respective Benefit Program.

Your Eligibility

You are eligible for the Benefit Program(s) shown in Appendix A if you are an active full-time employee working a minimum of 30 hours per week for the City of Jacksonville in a position covered by any collective bargaining agreement with the Fraternal Order of Police Local 5-30 (FOP) or the International Association of Fire Fighters Local 122 (IAFF). Union employees are eligible for coverage if your benefits are covered under the terms of the collective bargaining agreement between the Employer and your applicable Union.

You are eligible for the Benefit Program(s) shown in Appendix A if you are an active full-time employee working a minimum of 30 hours per week for the City of Jacksonville in an Appointed Position with the Jacksonville Sheriff's Office or Jacksonville Fire and Rescue Department.

You are eligible for the Benefit Program(s) shown in Appendix A if you are an active full-time employee working a minimum of 30 hours per week for the Jacksonville Police Officers and Fire Fighters Health Insurance Trust, the Fraternal Order of Police, or the International Association of Fire Fighters.

You are eligible for the Benefit Program(s) shown in Appendix B if you are an eligible Retiree. Eligible Retirees includes those who retired in a position covered by any collective bargaining agreement between the City of Jacksonville and FOP or IAFF with at least 20 years of service or obtained disability retirement. Eligible Retirees also includes a surviving spouse, surviving dependent, or anyone otherwise entitled to a Eligible Retiree's survivor benefits.

- *See Appendix C for eligible active union, appointed bargaining units, and retiree information.*

Unless otherwise communicated to you in writing by the Trust, the following individuals are not eligible for benefits: part-time employees, employees of a temporary or staffing firm, payroll agency or leasing organization, independent contractors and other individuals who are not on the Trust's payroll, as determined by the Trust.

The Trust's determination of eligibility is conclusive and binding for Plan purposes. No reclassification of a person's status, for any reason, by a third party (whether by a court, governmental agency or otherwise) will change a person's eligibility for benefits under the Plan.

Eligible Dependents

The definition of eligible dependents and other provisions, such as whether you may enroll your eligible dependents in a Benefit Program, are defined in the insurance certificates for each Benefit Program. Those provisions, and the definition of a dependent for each Benefit Program, are incorporated by reference herein.

Unless otherwise defined by the insurance certificate for a Benefit Program, your eligible dependents include:

- your legal spouse;
- your child under age 26 regardless of financial dependency, residency with you, marital status, or student status;

- *Medical only*: your child over the age of 26 through the end of the month in which they turn 30 if they meet the following criteria:
    - Unmarried
    - No dependents of their own
    - Dependent on employee for financial support
    - Not offered coverage through another group or individual plan
    - Not entitled to benefits under Title XVIII of Social Security Act
    - Resident of Florida or a full or part-time student living outside the state of Florida
- your unmarried child of any age who is not capable of self-support due to a physical or mental disability that occurred before age 26, whose disability is continuous, and who is principally supported by you.

For purposes of the Plan, your child includes:

- your biological child;
- your legally adopted child (including any child lawfully placed for adoption with you);
- your stepchild;
- a foster child who has been placed with you by an authorized placement agency or by judgment decree or other court order;
- a grandchild for whom you are in a parent-child relationship for up to 18 months
- a child for whom you are the court-appointed legal guardian;
- an eligible child for whom you are required to provide coverage under the terms of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN).

If you have any questions regarding dependent coverage under a Benefit Program, check with the Plan Administrator. It is your responsibility to notify the Trust if your dependent becomes ineligible for coverage.

An eligible dependent does not include a person enrolled as an employee under the Plan or any person who is covered as a dependent of another employee covered under the Plan. If you and your spouse are both employed by the City of Jacksonville, each of you may elect your own coverage (based on your own eligibility for benefits) or one of you may be enrolled as a dependent on the other's coverage, but only one of you may cover your dependent children.

- *See Appendix D for details on dependents and eligible plans*

Taxability of Overage Dependent Benefits

Overage Dependent benefits do not qualify for the same favorable tax treatment given to dependents under the age of 26 under Federal law. Under current tax law, you are required to be taxed on the value of health benefits provided to a overage dependent who does not meet the definition of a dependent under Code Section 152(d). In most cases, the value of your overage dependent's coverage will be taxable to you and treated as "imputed income." This is the term that the IRS applies to the value of any benefit or service that is considered income for the purposes of calculating your Federal taxes. The full value of coverage will be included in your pay as taxable wages (even though you do not receive the cash). Federal income tax, FICA, state, and other applicable payroll taxes will be withheld on the value of the coverage. You should consult with your tax advisor if you have questions about your specific tax situation.

Proof of Dependent Eligibility

The Trust reserves the right to verify that your dependent is eligible or continues to be eligible for coverage under the Plan's Benefit Programs. If you are asked to verify a dependent's eligibility for coverage, you will receive a notice describing the documents that you need to submit. To ensure that coverage for an eligible dependent continues without interruption, you must submit the required proof within the designated time period. If you fail to do so, coverage for your dependent may be canceled.

When Coverage Begins

To be eligible for a Benefit Program, you must satisfy the eligibility requirements described for that Benefit Program in the applicable insurance certificates and other materials provided for that Benefit Program. Unless otherwise stated in those materials, your coverage begins the first of the month following 30 days of employment. Members who worked for the Employer in another role and transferred in to an eligible bargaining unit covered by this Plan will have the waiting period waived.

Certain benefits, such as supplemental products, may require you to be actively at work to be initially eligible for a Benefit Program and for any change in coverage to take effect. See the materials provided by your Insurer to determine when this applies to you.

If you terminate employment and are subsequently rehired, you will be treated as a new employee and will need to satisfy all eligibility requirements to be covered under the Plan.

Unless stated otherwise in your insurance certificates, coverage for your eligible dependents begins on the same day as your initial eligibility provided you timely enroll your dependents in coverage. If you acquire a new dependent through marriage, birth, adoption or placement for adoption, you can add your new dependent to your coverage as long as you enroll the dependent within 30 days of the date on which they became eligible. If you wait longer than 30 days, you may be required to wait until the Plan's next open enrollment period to enroll your new dependent for coverage.

Look-back Measurement Method for Determining Full-time Employee Status

The Employer uses the look-back measurement method to determine who is a full-time employee for purposes of the Plan's health care benefits. The look-back measurement method is based on Internal Revenue Service (IRS) final regulations.

The look-back measurement method applies to:

- All employees

The look-back measurement method involves three different periods:

- Measurement period
- Stability period
- Administrative period

The measurement period is a period for counting your hours of service. Different measurement periods apply to ongoing employees, new employees who are variable hour, seasonal or part-time, and new non-seasonal employees who are expected to work full time.

If you are an ongoing employee, this measurement period is called the "standard measurement period." Your hours of service during the standard measurement period will determine your eligibility for the Plan's health care benefits for the stability period that follows the standard measurement period and any administrative period.

If you are a new employee who is variable hour, seasonal or part-time, this measurement period is called the “initial measurement period.” Your hours of service during the initial measurement period will determine your eligibility for the Plan’s health care benefits for the stability period that follows the initial measurement period and any administrative period.

If you are a new non-seasonal employee who is expected to work full time, the Employer will determine your status as a full-time employee who is eligible for the Plan’s health care benefits based on your hours of service for each calendar month. Once you have been employed for a certain length of time, the measurement rules for ongoing employees will apply to you.

The stability period is a period that follows a measurement period. Your hours of service during the measurement period will determine whether you are considered a full-time employee who is eligible for health care benefits during the stability period. As a general rule, your status as a full-time employee or a non-full-time employee is “locked in” for the stability period, regardless of how many hours you work during the stability period, as long as you remain an employee of the Employer. There are exceptions to this general rule for employees who experience certain changes in employment status.

An administrative period is a short period between the measurement period and the stability period when the Employer and the Trust performs administrative tasks, such as determining eligibility for coverage and facilitating Plan enrollment. The administrative period may last up to 90 days. However, the initial measurement period for new employees and the administrative period combined cannot extend beyond the last day of the first calendar month beginning on or after the one-year anniversary of the employee’s start date (totaling, at most, 13 months and a fraction of a month).

Special rules may apply in certain circumstances, such as when employees are rehired by the employer or return from unpaid leave.

The rules for the look-back measurement method are very complex. Keep in mind that this information is a summary of how the rules work. More complex rules may apply to your situation.

The Trust intends to follow applicable IRS guidance when administering the look-back measurement method. If you have any questions about this measurement method and how it applies to you, please contact the Plan Administrator.

Your Contribution for Coverage

Each year, the Trust will evaluate all costs and may adjust the cost of coverage during the next annual enrollment. Any required contribution amount will be provided to you by the Trust in your enrollment materials. You may also request a copy of any required contribution amounts from the Plan Administrator.

For most benefits you pay the employee cost of Plan premiums through pre-tax or after-tax payroll deductions, depending on your election, each pay period.

You must elect coverage for yourself in order to cover your eligible dependents. Your coverage for certain Benefit Programs may also be subject to deductibles, copayments, coinsurance, or other fees as described in the materials for the coverage you select.

Enrolling for Coverage

Initial Enrollment

As a newly eligible employee, you will receive enrollment information when you first become eligible for benefits. Your enrollment materials and online enrollment system will provide the

options available to you and your share of the premium cost, as well as any default coverage you will be deemed to have elected if you do not make an election by the specified deadline. For each Benefit Program, you will need to make your coverage elections by the deadline shown in your enrollment materials. When you enroll in the Plan, you authorize the Employer to deduct any required premiums from your pay through salary reduction. If you do not enroll for coverage when initially eligible, you will be deemed to have elected no coverage or the default coverage designated by the Trust for a Benefit Program.

The elections you make will remain in effect until the next December 31, unless a qualifying life event occurs (see below). Your insured benefits may have a different coverage period. Your enrollment materials will tell you if a different 12-month coverage period applies to your elections for an insured benefit. After your initial enrollment, you will enroll during the designated annual open enrollment period.

Annual Open Enrollment Period

Each year during a designated open enrollment period, you will be given an opportunity to make your elections for the upcoming year. Your enrollment materials and online enrollment system will provide the options available to you and your share of the premium cost, as well as any default coverage you will be deemed to have elected if you do not make an election by the specified deadline. In general, the elections you make will take effect on January 1 and stay in effect through December 31, the Plan Year, unless you have a qualifying change in status. The Plan Year may differ from the policy year of an insured benefit. Your enrollment materials and online election form will tell you if a different 12-month coverage period applies to your elections for an insured benefit. Also, you should refer to the insurance certificate provided by the Insurer for more information on how your benefits are affected by the policy year, including whether your deductible and out-of-pocket expenses accumulate over the Plan Year, policy year or other 12-month period.

Special Enrollment Rights

You may enroll for coverage outside of the Plan’s initial and annual open enrollment periods if you experience a special enrollment event, as described below. Special enrollment rights apply to the Plan’s medical benefits. These rights, however, may not apply all Benefit Programs (for example, these rights do not apply to Benefit Programs that are “excepted benefits” under HIPAA). You should review your insurance certificate and check with the Plan Administrator if you have questions about enrolling in a Benefit Program.

Active Employees:

- If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health coverage is in effect, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the Trust stops contributing toward the other coverage). However, you must request enrollment within 30 days after the other coverage ends (or after the Trust stops contributing toward the other coverage).
- If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after coverage ends under Medicaid or a state CHIP.

- If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.
- If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state CHIP with respect to coverage under this Plan, you may be able to enroll yourself and your dependents in this Plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

Retirees

- If you decline enrollment for an eligible dependent (including your spouse) while other health coverage is in effect, you may be able to enroll your dependents in this Plan if your dependents lose eligibility for that other coverage (or if the Trust stops contributing toward the other coverage). However, you must request enrollment within 30 days after the other coverage ends (or after the Trust stops contributing toward the other coverage).
- If you decline enrollment for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll your dependents in this Plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after coverage ends under Medicaid or a state CHIP.
- If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.
- If your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state CHIP with respect to coverage under this Plan, you may be able to enroll your dependents in this Plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

You will need to provide documentation of your special enrollment event in order to enroll outside of an initial or annual open enrollment period. Contact the Plan Administrator to determine what information you will need to provide.

Code Section 125 Status of Plan

This Plan is designed and administered in accordance with Section 125 of the Internal Revenue Code and underlying regulations. This enables you to pay your share of premiums for certain Benefit Programs on a pre-tax basis, as permitted by the Employer. Review your election and enrollment materials to determine which Benefit Programs permit pre-tax premium payments and are subject to the Section 125 rules. Pre-tax dollars come out of your pay before federal income and Social Security taxes are withheld (and, in most states, before state taxes are withheld). This gives your contributions a special tax advantage and lowers the actual cost of participating in the Plan to you. Neither the Employer nor any fiduciary under the Plan will in any way be liable for any taxes or other liability incurred by you by virtue of your participation in the Plan.

Because of this favorable tax-treatment, there are certain restrictions on when you can make changes to your elections for Section 125 benefits. Generally, your elections stay in effect for the Plan Year (or other 12-month period of coverage for an insured benefit, as designated in your

enrollment materials and elections) and you can make changes only during an annual open enrollment period. However, depending on the Plan's rules for mid-year election change events, you may be able to change your elections if a qualifying life event occurs as described below.

Qualifying Life Events

The elections you make under the Plan are generally irrevocable during the Plan Year (or other 12-month coverage period that applies to a Benefit Program, as indicated in your enrollment and election materials). This means, for example, that once you have elected how much pre-tax income you will use to pay for the Plan's Benefit Programs, you are locked into that election until the next annual enrollment period. However, there are certain limited situations that allow you to change your Plan elections outside of the annual enrollment period, depending on the Plan's eligibility rules for a Benefit Program. You may change your elections if a "qualifying life event" occurs and you make an election change that is consistent with the event, as determined by the Plan Administrator.

The change in coverage must be consistent with the change in status. You can add or remove coverage for you, your spouse, or your dependent. But you cannot change plans mid-year unless you have a change in residency that would impact eligibility. Depending on the Plan's eligibility rules for a Benefit Program, a "qualifying life event" that may allow you to change your election includes the following events:

- a change in your legal marital status, including marriage, divorce, death of spouse
- a change in the number of dependents, including birth, adoption, placement for adoption or death of a dependent
- a change in employment status for you, a spouse or a dependent that affects eligibility
- a change in a dependent child's eligibility
- a change in residency that would impact eligibility (for example, moving out of a plan's coverage area)
- the cost of a Benefit Program significantly changes
- coverage under a Benefit Program is significantly curtailed or ceases
- your spouse's or dependent's plan has a different enrollment period and you need to make a change to account for that other coverage
- you, your spouse or your dependent loses group coverage sponsored by a governmental or educational institution
- your change corresponds with a HIPAA special enrollment right (described above)
- a court order, such as a QMCSO or NMSN, mandates coverage for an eligible dependent child
- you, a spouse or a dependent enrolls in Medicare or Medicaid
- you take an FMLA leave (if applicable)
- a change in your employment status to less than 30 hours of service per week on average even if the reduction does not result in loss of Plan eligibility
- eligibility for a special enrollment period to enroll in a qualified health plan (QHP) through the Marketplace or seeking to enroll in a QHP during the Marketplace's annual open enrollment period

- any other election change event recognized by the IRS and permitted by the Plan Administrator

Also, if the cost of a Benefit Program changes by an insignificant amount during a coverage period, the Plan Administrator may automatically make a corresponding change to your election. You should report an election change event to the Plan Administrator as soon as possible, but no later than 30 days after the event occurs. Contact the Plan Administrator if you have questions about when you can change your elections.

When Coverage Ends

Except as otherwise provided in the insurance certificate, your coverage under this Plan ends on the last day of the month in which your employment terminates or upon your death, unless benefits are extended.

Coverage for your covered dependents ends on the date your coverage ends, or, if earlier, on the last day of the month in which your dependent is no longer eligible for coverage under the Plan.

Coverage will also end for you and your covered dependents as of the date the Trust terminates this Plan or, if earlier, the effective date you request coverage to be terminated for you and/or your covered dependent.

If your coverage under the Plan ends for reasons other than the Trust's termination of all coverage under the Plan, you and/or your eligible dependents may be eligible to elect to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) as described below.

Cancellation of Coverage

If you fail to pay any required premium for coverage under a Benefit Program, coverage for you and your covered dependents will be canceled for that Benefit Program and no claims incurred after the effective date of cancellation will be paid.

Rescission of Coverage

Coverage under the Plan may be rescinded (canceled retroactively) if you or a covered dependent performs an act, practice or omission that constitutes fraud, or you make an intentional misrepresentation of material fact as prohibited by the terms of the Plan. A rescission of coverage is an adverse benefit determination that you may dispute under the Plan's claims and appeals procedures. If your coverage is being rescinded due to fraud or intentional misrepresentation of material fact, you will receive at least 30 days' advance written notice of the rescission. This notice will outline your appeal rights under the Plan. Benefits under the Plan that qualify as "excepted benefits" under HIPAA are not subject to these restrictions on when coverage may be rescinded. Some types of retroactive terminations of coverage are permissible even when fraud or intentional misrepresentation are not involved. Coverage may be retroactively terminated for failure to timely pay required premiums or contributions as required by the Plan.

Also, coverage may be retroactively terminated to the date of your divorce if you fail to notify the Plan of your divorce and you continue to cover your ex-spouse under the Plan. Coverage will be canceled prospectively for errors in coverage or if no fraud or intentional misrepresentation was made by you or your covered dependent.

The Plan reserves the right to recover from you and/or your covered dependents any benefits paid as a result of the wrongful activity that are in excess of the contributions paid. In the event the Plan terminates or rescinds coverage for gross misconduct on your behalf, continuation coverage under COBRA may be denied to you and your covered dependents.

If You Take a Leave of Absence (FMLA)

If you take an approved FMLA leave of absence, your coverage could continue for the duration of your leave, as long as you continue to pay your share of the cost as required under the Employer's FMLA Policy. You will need to contact the Employer and the Trust Plan Administrator in order to maintain benefits while on an approved FMLA leave of absence. Coverage for other benefits can be found in the insurance certificates for the respective Benefit Programs in which you have enrolled.

If You Take a Military Leave of Absence

Your right to continued participation in a group health plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). Accordingly, if you are absent from work due to a period of active duty in the military you may elect to continue your group health plan coverage. If you are absent for less than 31 days, you will pay the regular employee share of the cost of the health coverage. If the absence is for 31 or more days, the cost of continuation coverage may not exceed 102% of the full cost of your health coverage.

Continuation coverage will terminate on the earlier of:

- The last day of the 24 month period beginning on the first day of military leave, or
- The date you fail to apply for reemployment, as required under USERRA, after returning from military leave.

USERRA continuation coverage is considered alternative coverage for purposes of COBRA. Therefore, if you elect USERRA continuation coverage, COBRA coverage will generally not be available.

Your Health Care Coverage

You should refer to the materials provided by the Insurer for information concerning any limitations, waiting periods before coverage begins, maximum benefits payable, when coverage ends, exclusions, age reductions, or reductions for other benefits that may apply.

The following health care Benefit Programs are administered by the Insurer(s) listed in Appendix A:

- Medical/Prescription Drug
- Dental
- Vision
- Supplemental Products

Participation

To become a participant in the above Benefit Program(s), you must meet all eligibility requirements and enroll in coverage. You may also enroll your dependents if they are eligible dependents as defined in the Insurer's benefits booklets.

Benefits Provided

The benefits provided under each Benefit Program are more fully described in the Certificate of Insurance/Coverage and other benefits booklets provided by the Insurer.

Your health care benefits are delivered through a network of participating physicians, hospitals, and other providers who have agreed to provide services at a negotiated cost.

You may choose from several types of medical plans or programs of benefits under this Plan, including:

- an HMO (Health Maintenance Organization)
- a PPO (Preferred Provider Organization)
- an EPO (Exclusive Provider Organization)

When you use network providers, the Plan pays the negotiated amount of covered expenses (after meeting any deductible) to your provider and there are no claim forms to complete. Certain medical options, such as an EPO or HMO, require services to be received only from network providers in order to be covered. You must use network providers in order to receive the maximum benefit payable under the Plan if you are enrolled in this type of plan.

For a listing of current network health care providers (at no cost to you), contact the Insurer at the telephone number or website shown later in this booklet.

Certain medical options, such as an HMO or POS, may require you to select a primary care physician (“PCP”) to coordinate your care. If so, you may designate any PCP who participates in the network and who is available to accept you or your family members. For dependent children, you may designate a pediatrician as the PCP. You do not need prior authorization from the Insurer or your PCP to obtain access to obstetrical or gynecological care from a network professional who specializes in obstetrics or gynecology. The network professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For information on how to select a PCP, and for a list of participating primary care physicians, contact the Insurer at the telephone number or website shown later in this booklet.

Your Dental Coverage

The following type(s) of dental plans or programs of benefits are included under this Plan:

- a DPPO (Dental Preferred Provider Organization)
- a DMO (Dental Maintenance Organization)

When you use network providers, the Plan pays the negotiated amount of covered expenses (subject to applicable deductible and coinsurance) to your provider and there are no claim forms to complete. The provider will not balance bill you for the discount provided on the claims. Certain dental options, such as a DMO, may require services to be received only from network providers in order to be covered. You must use network providers in order to receive the maximum benefit payable under the Plan if you are enrolled in this type of plan.

For a listing of current network dental care providers (at no cost to you), contact the Insurer for the dental care plan or program at the telephone number or website shown later in this booklet.

Source of Payments

Benefits for covered services and expenses under the Benefit Program(s) listed above are paid by the Insurer and are guaranteed under the insurance contracts. Any cost-sharing provisions, such as your deductible, co-payment, or coinsurance, are set forth in the materials furnished by the Insurer.

Any required premiums for coverage will be shown in your enrollment materials. Your premiums will be deducted from your pay on either a pre-tax or after-tax basis, depending on your election.

Limitations and Exclusions

The materials for each Benefit Program contain information about limitations on benefits, covered preventive care services, prescription drugs, pre-authorizations required, utilization reviews required, obtaining emergency care, exclusions and expenses not covered, medical tests and procedures covered, any limits or caps on certain coverage, and relative costs for in-network and out-of-network services.

Continuation of Health Care Coverage through COBRA

If your health care coverage under the Plan ends for reasons other than the Trust's termination of all coverage under the Plan, you and/or your eligible dependents may be eligible to elect to continue coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). Health care coverage may continue at your own expense for a specific length of time. See the section entitled "Your HIPAA/COBRA Rights" for additional information. Please note that if your Employer has less than 20 employees, Federal COBRA legislation may not apply to you, but you may instead be eligible for COBRA benefits available through your state. Contact your Insurer for additional information as these provisions vary from state to state.

For More Information

If you have a question about a covered service, or for more information about a specific procedure, coverage of new drugs, tests, or experimental or investigative treatments, you should consult the materials furnished by the Insurer for the coverage in which you are enrolled.

Your Vision Coverage

The following type(s) of vision plans or programs of benefits are included under this Plan:

- Vision Plan

When you use network providers, the Plan pays the negotiated amount of covered expenses (subject to applicable deductible and coinsurance) to your provider and there are no claim forms to complete. The provider will not balance bill you for the discount provided on the claims. You must use network providers in order to receive the maximum benefit payable under the Plan if you are enrolled in this type of plan.

For a listing of current network vision care providers, contact the Insurer for the vision care plan or program at the telephone number or website shown later in this booklet.

Source of Payments

Benefits for covered services and expenses under the Benefit Program(s) listed above are paid by the Insurer and are guaranteed under the insurance contracts. Any cost-sharing provisions, such as your deductible, co-payment, or coinsurance, are set forth in the materials furnished by the Insurer.

Any required premiums for coverage will be shown in your enrollment materials. Your premiums will be deducted from your pay on either a pre-tax or after-tax basis, depending on your election.

Limitations and Exclusions

The materials for each Benefit Program contain information about limitations on benefits, covered preventive care services, prescription drugs, pre-authorizations required, utilization reviews required, obtaining emergency care, exclusions and expenses not covered, medical tests and procedures covered, any limits or caps on certain coverage, and relative costs for in-network and out-of-network services.

Continuation of Health Care Coverage through COBRA

If your health care coverage under the Plan ends for reasons other than the Trust's termination of all coverage under the Plan, you and/or your eligible dependents may be eligible to elect to continue coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). Health care coverage may continue at your own expense for a specific length of time. See the section entitled "Your HIPAA/COBRA Rights" for additional information. Please note that if your Employer has less than 20 employees, Federal COBRA legislation may not apply to you, but you may instead be eligible for COBRA benefits available through your state. Contact your Insurer for additional information as these provisions vary from state to state.

For More Information

If you have a question about a covered service, or for more information about a specific procedure, coverage of new drugs, tests, or experimental or investigative treatments, you should consult the materials furnished by the Insurer for the coverage in which you are enrolled.

Your Supplemental Plans

The following Benefit Program is fully insured and administered by the Insurer listed in Appendix A:

- Supplemental Plans

Participation

To become a participant in the Supplemental Plans Benefit Program, you must meet all eligibility requirements and enroll in coverage. You may elect to cover your eligible dependents.

Benefits Provided

The benefits provided under the Supplemental Plans Benefit Program are more fully described in the materials provided to you by the Insurer.

Source of Payment

Benefits under the program are paid by the Insurer and are guaranteed under the applicable insurance contract.

Any required premiums for coverage will be shown on your Election Form. Your premiums are deducted on an after-tax basis.

Plan Limitations and Exclusions

You should refer to the materials provided by the Insurer for information concerning any limitations, exclusions, or reduction for other benefits that may apply to your coverage.

For More Information

If you have any questions about the Supplemental Plans Benefit Program, you should consult your Certificate of Insurance or other materials provided by the Insurer.

Administrative Information

The following sections contain legal and administrative information you may need to contact the right person for information or help. Although you may not use this information often, it can be helpful if you want to know:

- how to contact the Plan Administrator;
- how to contact the Insurer or Claims Administrators;
- what to do if a benefit claim is denied; and
- your rights Federal laws such as COBRA.

IMPORTANT: This Summary Plan Description may not include language or certain mandated coverage required by state insurance laws. State mandated coverage may be addressed separately in the insurance certificates provided by the Insurer.

Plan Sponsor and Administrator

Jacksonville Police Officers and Fire Fighters Health Insurance Trust is the Plan Sponsor and the Plan Administrator for this Plan. You may contact the Plan Administrator at the following address and telephone number:

Plan Administrator
Jacksonville Police Officers and Fire Fighters Health Insurance Trust
625 Stockton Street
Jacksonville, FL 32204
800-978-0632

The Plan Administrator will have control of the day-to-day administration of this Plan and will serve without additional remuneration if such individual is an employee of the Employer. The Plan Administrator will have the following duties and authority with respect to the Plan:

- To prepare and file with governmental agencies all reports, returns, and all documents and information required under applicable law;
- To prepare and furnish appropriate information to eligible employees and Plan participants;
- To prescribe uniform procedures to be followed by eligible employees and participants in making elections, filing claims, and other administrative functions in order to properly administer the Plan;
- To receive such information or representations from the Employer, eligible employees, and participants necessary for the proper administration of the Plan and to rely on such information or representations unless the Plan Administrator has actual knowledge that the information or representations are false;
- To properly administer the Plan in accordance with all applicable laws governing fiduciary standards;
- To maintain and preserve appropriate Plan records.

In addition, the Plan Administrator has the discretionary authority to determine eligibility under all provisions of the Plan; correct defects, supply omissions, and reconcile inconsistencies in the Plan; ensure that all benefits are paid according to the Plan; interpret Plan provisions for all

participants and beneficiaries; and decide issues of credibility necessary to carry out and operate the Plan.

For fully insured benefits, unless otherwise expressly provided in the insurance policy or contract governing a Benefit Program, the Insurer shall be the Plan Administrator and Named Fiduciary only with respect to the benefits provided through the insurance policy or contract. The Insurer shall be responsible for determining eligibility for and the amount of benefits payable under the Benefit Program, and for prescribing claims procedures to be followed by Participants. The Insurer shall also be responsible for paying claims.

Plan Year

The Plan Year is January 1 through December 31.

Note: An insured benefit may use a policy year that differs from the Plan Year, with deductible and out-of-pocket expenses based on the policy year. Please refer to the insurance certificate and other materials provided by the Insurer to determine how the policy year impacts your benefits.

Type of Plan

This Plan is a called a “welfare plan”, which includes group health plans; they help protect you against financial loss in case of sickness or injury.

Identification Numbers

The Employer Identification Number (EIN) and Plan number for the Plan is:

EIN: 82-6808969 PLAN NUMBER: 501

Plan Funding and Type of Administration

Funding and administration of the Plan is as follows.

Type of Administration	The Plan is administered by the Trust through an arrangement with Insurers and third-party (claims) administrators. Insured benefits will be payable solely by the Insurer.
Funding	The Trust and employees both contribute to the Plan. Premiums are paid to the Insurers for fully insured Benefit Programs and benefits will be paid by the Insurer in accordance with the applicable insurance contract/policy.

Funding for this Plan shall consist of an aggregation of the funding for all Benefit Programs. The Trust shall have the right to insure any benefits under this Plan, to establish any fund or trust for the payment of benefits under this Plan, or to do neither and pay benefits under this Plan from its general assets, either as mandated by law or as the Trust deems advisable. In addition, the Trust shall have the right to alter, modify, or terminate any method or methods used to fund the payment of benefits under this Plan, including, but not limited to, any trust or insurance policy.

If any benefit is funded by the purchase of insurance, the benefit shall be payable solely by the Insurer.

Insurers/Claims Administrators

For fully insured Benefit Programs, the Insurer is responsible for administering benefits and paying claims. They may contract with a separate Claims Administrator to process claims. You may contact the Insurer/Claims Administrator directly, using the information listed below.

It is important to understand that if the terms of this SPD conflict with the terms of the insurance certificate regarding substantive rules for an insured Benefit Program (such as benefits and claims procedures), the terms of the insurance certificate will control, unless otherwise required by law.

Medical and Prescription Drug Benefits

Florida Blue
4800 Deerwood Campus Parkway
Jacksonville, FL 32246
800-352-2583
www.Floridablue.com

Express-Scripts
1 Express Way
St. Louis, MO 63121
877-732-3439
https://express-scripts.com/

UF Direct Health / Envolve Rx
800-959-3518
https://www.integratpa.com/

Dental Benefits

Delta Dental
1130 Sanctuary Parkway
Alpharetta, GA 30009
770-641-5411
https://www.deltadental.com/

Vision Benefits

Eyemed
3130 Broadway
Kansas City, MO 64111
866-800-5457
https://www.eyemed.com/en-us

Supplemental Plans

Unum Life Insurance Company of America
2211 Congress Street
Portland, ME 04103
800-635-5597
https://www.unum.com/

Agent for Service of Legal Process

For disputes arising under any fully insured Benefit Program, Service of Legal Process may be made upon the Insurer listed above. Service of Legal Process may also be served upon:

Jacksonville Police Officers and Fire Fighters Health Insurance Trust Health and Welfare Benefit Plan
625 Stockton Street
Jacksonville, FL 32204
800-978-0632

Service of Legal Process may also be served on the Plan Administrator.

No Obligation to Continue Employment

The Plan does not create an obligation for the Employer to continue your employment or interfere with the Employer's right to terminate your employment, with or without cause.

Severability

If any provision of this Plan is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions shall continue to be fully effective.

Payment of Benefits to Others

The Insurer/Claims Administrator, in its discretion, may authorize any payments due to be paid to the parent or legal guardian of any individual who is either a minor or legally incompetent and unable to handle his or her own affairs.

Expenses

All expenses incurred in connection with the administration of the Plan, are Plan expenses and will be paid from the general assets of the Trust.

Fraud

No payments under the Plan will be made if you or a provider of services attempts to perpetrate a fraud upon the Plan with respect to any such claim. The Insurer/Claims Administrator will have the right to make the final determination of whether a fraud has been attempted or committed upon the Plan or if a misrepresentation of fact has been made. The Plan will have the right to recover any amounts, with interest, improperly paid by the Plan by reason of fraud. If you or a covered dependent attempts or commits fraud upon the Plan, your coverage may be terminated and you may be subject to disciplinary action by the Trust, up to and including termination of employment.

Indemnity

To the full extent permitted by law, the Trust will indemnify the Plan Administrator and each other employee who acts in the capacity of an agent, delegate, or representative ("Plan Administration Employee") of the Plan Administrator against any and all losses, liabilities, costs and expenses incurred by the Plan Administration Employee in connection with or arising out of any pending, threatened, or anticipated action, suit or other proceeding in which the Employee may be involved by having been a Plan Administration Employee.

Compliance with State and Federal Mandates

Each Benefit Program will comply to the extent possible with the requirement of all applicable laws, including but not limited to: COBRA, USERRA, HIPAA, the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), the Women's Health and Cancer Rights Act of 1998, FMLA, the Mental Health Parity and Addiction Equity Act of 2008, PPACA, HITECH, Michelle's Law (if applicable), and Title I of GINA (prohibiting the use of genetic information to discriminate with respect to health insurance premiums, contributions or other restricted purposes).

Refund of Premium Contributions

For fully insured Benefit Programs, the Plan will comply with DOL guidance regarding refunds (e.g., dividends, demutualization, experience adjustments, and/or medical loss ratio rebates) of insurance premiums. Where any refund is determined to be a plan asset to the extent amounts are attributable to participant contributions, such assets will be: 1) distributed to current plan participants within 90 days of receipt, 2) used to reduce participants' portion of future premiums under the Plan (e.g., premium holiday); or 3) used to enhance future benefits under the Plan. Such determination will be made by the Plan Administrator, acting in its fiduciary capacity, after weighing the costs to the Plan and the competing interest of participants, provided such method is reasonable, fair, and objective.

Nondiscrimination

The Plan is intended to be nondiscriminatory under Code Section 125. Code Section 125 prohibits discrimination in favor of highly compensated individuals with respect to eligibility to participate, highly compensated participants with respect to benefits and contributions and key employees with respect to total Plan contributions. If the Plan Administrator determines, at any time, that the Plan may fail to satisfy these nondiscrimination requirements, the Plan Administrator may take such action as it deems appropriate to comply with the nondiscrimination requirements. This action may include, for example, modifying the elections of highly compensated or key employees without their consent.

No Guarantee of Tax Consequences

Neither the Plan Administrator nor the Trust makes any representation, guarantee or warranty that any amount paid as premiums or distributed as benefits under the Plan will be excludable from your gross income for federal or state income tax purposes (or that any other state or federal tax treatment will apply or be available to you). It is your responsibility to determine whether payments are excludable from your gross income for federal and state income tax purposes.

Future of the Plan

The Trust expects that the Plan will continue indefinitely. However, the Trust has the sole right to amend, modify, suspend, or terminate all or part of the Plan at any time.

The Trust may also change the level of benefits provided under the Plan at any time. If a change is made, benefits for claims incurred after the date the change takes effect will be paid according to the revised Plan provisions. In other words, once a change is made, there are no rights to benefits based on earlier Plan provisions.

Claims Procedures/Coordination of Benefits

This section describes what you must do to file or appeal a claim for services. It also describes how benefits under this Plan are coordinated with other benefits to which you or a covered dependent might be entitled.

Claims and Appeals

For fully insured Benefit Programs, the claims procedures, including issues related to payment, preauthorization approval, or utilization review, as well as the time frames for submitting claims, are set forth in the insurance certificates.

If your claim is denied and you disagree and want to pursue the matter, you must file a First Level Appeal with the respective Insurer. A rescission of coverage is also considered an adverse benefit determination that triggers your right to file an appeal. You or your authorized representative may appeal a denied claim within the time frame provided in the insurance certificates for that Benefit Program. Different time frames apply to healthcare claims and disability-related claims. You will have the right to submit for review, written comments, documents, records, and other information related to the claim; and to request, free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claim.

The Insurer, acting on behalf of the Plan, has full and exclusive authority and discretion to construe and interpret the provisions of the Program, to determine questions of coverage, and entitlement to and termination of benefits, and to make factual findings. If the Insurer denies your claim (in whole or in part) during a First Level Appeal, you may file a Second Level Appeal. If after such review, the Insurer continues to deny the claim in full or in part, you will be notified of the decision in writing.

The Insurer’s decision will include specific reasons for the decision, written in a manner calculated to be easily understood, with specific references to the Benefit Program’s provision or provisions, including any internal rules, guidelines, protocol, or other similar criterion relied upon, on which the appeal decision is based. It will also include a statement of your right to access and receive copies of all documents, records, and other information relevant to your appeal.

Exhaustion Required

The decision of the Insurer for fully insured Benefit Programs shall be final and conclusive on all persons claiming benefits under the Benefit Program, subject to applicable law. No other actions may be brought by any person until an appeal for denied benefits has been brought and been denied (or deemed denied) as described above under the respective claims procedure. You must exhaust all remedies available to you before bringing legal action. You cannot take any other steps unless and until you have exhausted all appeals. For example, if your claim is denied and you do not use the appeals procedures, the denial of your claim will be conclusive and cannot be challenged, even in court.

Non-Duplication of Benefits / Coordination of Benefits

If you (or an eligible dependent) are covered by another employer’s plan, the two plans work together to avoid duplicating payments. This is called non-duplication or coordination of benefits.

The Insurer is responsible for ensuring that eligible expenses are coordinated with benefits from:

- other employers’ plans;
- certain government plans; and

- motor vehicle plans when required by law.

The Insurer may request information about other coverage you may have. You are required to provide this information to ensure that claims are properly paid.

Health Care Coverage Coordination with Medicare

If you are actively employed after becoming eligible for Medicare, your coverage under the Plan will be coordinated with Medicare. Which plan pays first ("primary") is determined by whether your Employer is considered a small or large group employer. Generally, for large group employer plans, Medicare requires the employer's plan to pay first and Medicare pays second ("secondary"). You should check with the Trust if you become eligible for Medicare while employed to determine if the Employer's coverage will be primary or secondary.

The Plan also coordinates with Medicare as follows.

- **End-stage renal disease**—If you or a covered dependent is eligible for Medicare due to end-stage renal disease, this Plan will be primary for the first 30 months of dialysis treatment; after this period, this Plan will be secondary to Medicare for this disease only.
- **Mandated coverage under another group plan**—If a person is covered under another group plan and Federal law requires the other group plan to pay primary to Medicare, this Plan will be tertiary (third payer) to both the other plan and Medicare.

Subrogation and Reimbursement

If you or your dependent receives benefits in excess of the amount payable under the Plan, the Insurer has a right to subrogation and reimbursement. Subrogation applies when the Insurer has paid benefits for a sickness or injury for which a third party is considered responsible (e.g., an insurance carrier if you are involved in an auto accident).

The Plan Administrator has delegated all subrogation rights and third party recovery rights to the Insurer of each fully insured Benefit Program. The Insurer shall undertake reasonable steps to identify claims in which the Plan has a subrogation interest and shall manage subrogation cases on behalf of the Plan. You are required to cooperate with the Insurer to facilitate enforcement of its rights and interests.

These provisions shall not apply where subrogation is specifically prohibited by enforceable law.

Your HIPAA Rights

Health Insurance Portability and Accountability Act (HIPAA)

Title II of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations at 45 CFR Parts 160 through 164 (HIPAA) contain provisions governing the use and disclosure of Protected Health Information (PHI) by group health plans, and provide privacy rights to participants in those plans. These rules are called the HIPAA Privacy Rules.

You will receive a “Notice of Privacy Practices” from the Administrator(s) and/or Insurer(s) that contains information about how your individually identifiable health information is protected under the HIPAA Privacy Rules and who you should contact with questions or concerns.

The HIPAA Privacy Rules apply to group health plans. These plans are commonly referred to as “HIPAA Plans” and are administered to comply with the applicable provisions of HIPAA. PHI is individually identifiable information created or received by HIPAA Plans that relates to an individual’s physical or mental health or condition, the provision of health care to an individual, or payment for the provision of health care to an individual. Typically, the information identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper or oral. When PHI is in electronic form it is called “ePHI.”

The HIPAA Plans may disclose PHI to the Plan Sponsor only as permitted under the terms of the Plan, or as otherwise required or permitted by HIPAA. The Plan Sponsor agrees to use and disclose PHI only as permitted or required by the HIPAA Privacy Rules and the terms of the Plan.

The HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose enrollment and disenrollment information to the Plan Sponsor. Also, the HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the information for the purposes of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending or terminating the Plan. “Summary Health Information” means information that summarizes the claims history, claims expenses or types of claims experienced by individuals covered under the HIPAA Plans and has almost all individually identifying information removed. The HIPAA Plans may also disclose PHI to the Plan Sponsor pursuant to a signed authorization that meets the requirements of the HIPAA Privacy Rules. Other than these disclosures, the Plan Sponsor will not create or receive PHI from the HIPAA Plans.

Your COBRA Continuation Coverage Rights

NOTE: *Federal COBRA legislation generally applies only to employers with more than 20 employees. If your employer has less than 20 employees, this Section will not apply to you but you may instead be eligible for COBRA benefits available through your state. Many, but* ***not all*** *states, have enacted "mini" COBRA laws which are similar to the Federal COBRA law described below in that they provide extended benefits to employees of small employers.*

The provisions vary substantially from state to state. States can enact different limits and timeframes for continuing coverage. You should contact your Insurer for complete and current details regarding any COBRA continuation coverage that may be available to you.

The following section applies to you only if you are covered by Federal COBRA coverage. Again, to find out more about coverage offered by your state for small employers, contact your Insurer or state Insurance Commission.

Continuing Health Care Coverage through COBRA

This section provides an overview of COBRA continuation coverage. The coverage described may change as permitted or required by applicable law. When you first enroll in coverage, you will receive from the Plan Administrator/COBRA Administrator your initial COBRA notice. This notice and subsequent notices you receive will contain current requirements applicable for you to continue coverage.

The length of COBRA continuation coverage (COBRA coverage) depends on the reason that coverage ends, called the "qualifying event." These events and the applicable COBRA continuation period are described below.

If you and/or your eligible dependent(s) choose COBRA coverage, the Trust is required to offer the same medical and prescription drug coverage that is offered to similarly situated employees. Proof of insurability is not required to elect COBRA coverage. In other words, you and your covered dependents may continue the same healthcare coverage you had under the Plan before the COBRA qualifying event.

If you have a new child during the COBRA continuation period by birth, adoption, or placement for adoption, your new child is considered a qualified beneficiary. Your new child is entitled to receive coverage upon his or her date of birth, adoption, or placement for adoption, provided you enroll the child within 30 days of the child's birth/adoption/placement for adoption. If you do not enroll the child under your coverage within 30 days, you will have to wait until the next open enrollment period to enroll your child.

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

For more information about the Marketplace, visit www.HealthCare.gov.

COBRA Qualifying Events and Length of Coverage

Each person enrolled in benefits will have the right to elect to continue healthcare benefits upon the occurrence of a qualifying event that would otherwise result in such person losing healthcare benefits. Qualifying events and the length of COBRA continuation are as follows:

18-Month Continuation

Healthcare coverage for you and your eligible dependent(s) may continue for 18 months after the date of the qualifying event if your:

- employment ends for any reason other than gross misconduct; or
- hours of employment are reduced.

If you or your eligible dependent is disabled at the time your employment ends or your hours are reduced, the disabled person may receive an extra 11 months of COBRA coverage in addition to the 18-month continuation period (for a total of 29 months of coverage from the date of the qualifying event). If the individual entitled to the disability extension has non-disabled family members who have COBRA coverage due to the same qualifying event, those non-disabled family members will also be entitled to the 11-month extension, including any child born or placed for adoption within the first 60 days of COBRA coverage.

The 11-month extension is available to any COBRA participant who meets all of the following requirements:

- he or she becomes disabled before or within the first 60 days of the initial 18-month coverage period (including a child born or placed for adoption with you); and
- he or she notifies the Plan Administrator (or its designated COBRA Administrator) within 60 days of the date on the Social Security Administration determination letter, and provides a copy of the disability determination; and
- he or she notifies the Plan Administrator (or its designated COBRA Administrator) before the initial 18-month COBRA coverage period ends.

You must also notify the Plan Administrator (or its designated COBRA Administrator) within 30 days of the date Social Security Administration determines that you or your dependent is no longer disabled.

36-Month Continuation

Coverage for your eligible dependent(s) may continue for up to 36 months if coverage is lost due to your:

- death;
- divorce or legal separation;
- eligibility for Medicare coverage; or
- dependent child’s loss of eligible dependent status under this Plan

Note: If any of these events (other than Medicare entitlement) occur while your dependents are covered under COBRA (because of an 18-month or 18-month plus 11 month extension qualifying event), coverage for the second qualifying event may continue for up to a total of 36 months from the date of the first COBRA qualifying event. In no case, however, will COBRA coverage be continued for more than 36 months in total.

If you become eligible for Medicare before a reduction in hours or your employment terminates, coverage for your dependents may be continued for up to 18 months from the date of your reduction in hours or termination of employment, or for up to 36 months from the date you became covered by Medicare, whichever is longer.

Cost of COBRA Coverage

You or your eligible dependent pay the full cost for healthcare coverage under COBRA, plus any required administrative fee up to two percent, or up to 102 percent of the full premium cost, except in the case of an 11-month disability extension where you may be required to pay up to 150 percent of the full premium cost for coverage.

When COBRA Coverage Ends

COBRA coverage for a covered individual will end when any of the following occur:

- The premium for COBRA coverage is not paid on a timely basis (monthly payments must be postmarked within the 30-day grace period, your initial payment must be postmarked within 45 days of your initial election).
- The maximum period of COBRA coverage, as it applies to the qualifying event, expires.
- The individual becomes covered under any other group medical plan.
- The individual becomes entitled to Medicare.
- The Trust terminates its group health plan coverage for all employees.
- Social Security determines that an individual is no longer disabled during the 11-month extension period.

Definitions

COBRA

The Consolidated Omnibus Budget Reconciliation Act. This Federal law allows a continuation of healthcare coverage in certain circumstances for Employers with 20 or more employees. Small Employers may be subject to individual state COBRA provisions.

Dependent

The definition of a dependent is defined in the insurance certificate and other materials provided by the Insurer. Under the PPACA, your dependent for health insurance coverage includes your child under age 26, regardless of financial dependency, residency with you, marital status, or student status.

Certain states may impose a different definition of dependent that extends coverage beyond age 26. You're the Trust also may elect a more generous definition of dependent or apply the above definition to other Benefit Programs. For questions regarding dependent eligibility, contact the Plan Administrator.

Employee

A person who is a fulltime employee and who is regularly scheduled to work for the Employer in an employer-employee relationship. The definition of an eligible employee is defined in the Plan Overview.

Election Form

The form used by employees to elect to participate in a Benefit Program and to authorize payment of premiums for such Benefit Program, where applicable.

Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) is a Federal law that provides for an unpaid leave of absence for up to 12 weeks per year for:

- the birth or adoption of a child or placement of a foster child in a participant's home;
- the care of a child, spouse or parent (not including parents-in-law), as defined by Federal law, who has a serious health condition;
- a participant's own serious health condition; or
- any qualifying exigency arising from an employee's spouse, son, daughter, or parent being a member of the military on "covered active duty". Additional military caregiver leave is available to care for a covered service member with a serious injury or illness who is the spouse, son, daughter, parent, or next of kin to the employee.

Generally, you are eligible for coverage under FMLA if you have worked for your Employer for at least one year; you have worked at least 1,250 hours during the previous 12 months; your Employer has at least 50 employees within 75 miles of your worksite; and you continue to pay any required premium during your leave as determined by the Employer. Various states also have enacted similar legislation for their residents. Covered employers must comply with the Federal or state provision that provides the greater benefit to their employees. If you have questions regarding your eligibility for FMLA coverage or your state's family medical leave provisions, if applicable, contact your Employer.

GINA

The Genetic Information Nondiscrimination Act of 2008, as amended.

HIPAA

Health Insurance Portability and Accountability Act of 1996, as amended.

HITECH

The Health Information Technology for Economic and Clinical Health Act, as amended.

Insurer

Any insurance company that fully insures (or partially insures) any benefit provided by this Plan or any Benefit Program.

Leased Employee

Leased employee as defined in the Internal Revenue Code, section 414(n), as amended.

Medicare

The program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

NMHPA

The Newborns' and Mother's Health Protection Act of 1996, as amended. Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Participant

An eligible employee who elects to participate in the Plan by completing the necessary Election Form on a timely basis, as provided by the Plan Administrator.

PPACA

The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010.

Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN)

Any court order that: 1) provides for child support with respect to the employee's child or directs the employee to provide coverage under a health benefit plan under a state domestic relations law, or 2) enforces a law relating to medical child support described in the Social Security Act, Section 1908, with respect to a group health plan. A QMCSO or an NMSN also may be issued through an administrative process established under state law. A participant must notify the Plan Administrator if he or she is subject to a QMCSO or an NMSN.

USERRA

The Uniformed Services Employment and Reemployment Rights Act of 1994; a Federal law covering the rights of participants who have a qualified uniformed services leave.

WHCRA

The Women's Health and Cancer Rights Act of 1998, as amended. Your medical coverage under the Plan includes coverage for a medically necessary mastectomy and patient-elected

reconstruction after the mastectomy. Specifically, for you or your covered dependent who is receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for: 1) All stages of reconstruction of the breast on which the mastectomy was performed; 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; 3) Prostheses; and 4) Treatment of physical complications at all stages of mastectomy, including lymphedema.

Adoption of the Plan

The Jacksonville Police Officers and Fire Fighters' Health Insurance Trust Health and Welfare Benefit Plan, as stated herein, is hereby adopted as of 01/01/2020. This document constitutes the basis for administration of the Plan.

IN WITNESS WHEREOF, the parties have caused this document to be executed on this _____ day of _____, 2020.

BY: _____

TITLE: _____

APPENDIX A

Benefit program for eligible Active Union members, Appointed members, and Staff members

BENEFIT PROGRAM	NAME OF INSURER/ CLAIMS ADMINISTRATOR	POLICY OR CONTRACT NUMBER(S)	START OF POLICY YEAR OR EFFECTIVE DATE OF COVERAGE	CLAIMS PROCEDURE & BENEFITS
GROUP MEDICAL INSURANCE PPO / HMO	FLORIDA BLUE INSURER/CLAIMS ADMINISTRATOR	D0800	January 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
GROUP PRESCRIPTION DRUG INSURANCE PPO / HMO	EXPRESS SCRIPTS INSURER/CLAIMS ADMINISTRATOR	D0800	January 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
GROUP MEDICAL / RX INSURANCE EPO	UF DIRECT HEALTH / ENVOLVE RX INSURER/CLAIMS ADMINISTRATOR	00861	January 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
GROUP DENTAL INSURANCE	DELTA DENTAL INSURER/CLAIMS ADMINISTRATOR	20175 (PPO) / 79213 (HMO)	January 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
GROUP VISION BENEFITS	EYEMED INSURER/CLAIMS ADMINISTRATOR	1023874	January 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
SUPPLEMENTAL PLANS	UNUM INSURER/CLAIMS ADMINISTRATOR	474245 / R0794859	January 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.

APPENDIX B

Benefit program for eligible Retirees

BENEFIT PROGRAM	NAME OF INSURER/ CLAIMS ADMINISTRATOR	POLICY OR CONTRACT NUMBER(S)	START OF POLICY YEAR OR EFFECTIVE DATE OF COVERAGE	CLAIMS PROCEDURE & BENEFITS
GROUP MEDICAL INSURANCE PPO / HMO	FLORIDA BLUE INSURER/CLAIMS ADMINISTRATOR	D0800	January 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
GROUP PRESCRIPTION DRUG INSURANCE PPO / HMO	EXPRESS SCRIPTS INSURER/CLAIMS ADMINISTRATOR	D0800	January 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
GROUP MEDICAL / RX INSURANCE EPO	UF DIRECT HEALTH / ENVOLVE RX INSURER/CLAIMS ADMINISTRATOR	00861	January 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
GROUP DENTAL INSURANCE	DELTA DENTAL INSURER/CLAIMS ADMINISTRATOR	20175 (PPO) / 79213 (HMO)	January 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.
GROUP VISION BENEFITS	EYEMED INSURER/CLAIMS ADMINISTRATOR	1023874	January 1	See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.

APPENDIX C

Eligible Active, Appointed, and Retiree Bargaining Units

Bargaining Units
Members employed in one of the following bargaining units meet the eligibility requirements for JPOFFHIT benefits:

Fraternal Order of Police (FOP) 5-30
0040 FOP, Police Officers and Sergeants
0041 FOP, Police Lieutenants and Captains
0042 Judicial Officers
0045 FOP, Correctional Officers
0046 FOP, Correctional Officers - Supervisory

International Association of Fire Fighters (IAFF) 122
0030 IAFF, Local 122 (Firefighters)
0141 IAFF, Local 122 (Fire Chiefs)

Appointed
0023 - Office of Sherriff / Officials
0083 - Office of Sherriff
0021 - Fire / Officials
0081 - Fire Appointed
0007 - Elected Officials

Appointed Members

Appointed members are eligible for the Trust benefits but do not fall under the terms of the Collective Bargaining Agreements with the Unions. These members could be eligible for benefits through their Employer and should verify eligibility and benefit programs through the Employer plan. No Appointed member can be enrolled in both the Trust plan and the Employer plan simultaneously. Appointed members must be enrolled in the Trust plans prior to their retirement to qualify for Retiree benefits.

Retirees

Eligible Retirees includes those who retired in a position covered by any collective bargaining agreement between the City of Jacksonville and the Fraternal Order of Police 5-30 or the International Association of Fire Fighters 122 with at least 20 years of service or obtained disability retirement. Eligible Retirees also includes a surviving spouse, surviving dependent, or anyone otherwise entitled to an Eligible Retiree’s survivor benefits.

Note: The pension office is the best resource to determine the full details of your retirement eligibility. This overview pertains to the rules of JPOFFHIT’s benefits after you retire completely.

Members move to the following bargaining units after their official retirement date:
888F Retired Pension- Fire
888P Retired Pension- Police
999C Retired Pension- Corrections

Exception: Some members may be part of a grandfathered population that work for or Retired from a job role at City of Jacksonville but their pension is paid through the Florida Retirement System (FRS). Members eligible for FRS pension will be currently assigned or moved to the below bargaining units at the time of retirement.

666F State Retirees- Fire
666P State Retirees- Police

Retiree Enrollment Period

Retirees after 1/1/2020
Retirees have up to 30 days after their official retirement date to elect Retiree benefits from the Trust. Retirees are eligible for the same medical, dental, and vision plans offered to them as an Active member. A member must elect the benefit(s) (medical, dental, or vision) they want to continue as a Retiree and members can change plans at the time of retirement. However, if a member does not elect a benefit at the time of retirement or later drops a benefit, they cannot re-enroll in the Trust plans later. Retirees are allowed to add eligible spouses and dependent children to their plan following a Qualified Life Event (QLE) or during an annual open enrollment period.

Retirees prior to 12/31/2019
Retirees could elect any medical, dental, or vision benefits from JPOFFHIT for the 2020 plan year as part of a one-time re-enrollment opportunity during the 2019 open enrollment period. If a Retiree did not take a benefit during this window or later drops a benefit, they cannot re-enroll in JPOFFHIT plans later. If a Retiree did re-enroll in the Trust, they can eligible spouses and dependent children to their plan following a Qualified Life Event (QLE) or during an annual open enrollment period.

Survivor and Continuing Family Member Eligibility

The Eligible Retiree definition also includes a surviving spouse, surviving dependent, or anyone otherwise entitled to an Eligible Retiree's survivor benefits.

Note: The pension office is the best resource to determine the full details of your survivor eligibility. This overview pertains to the rules of The Trust's benefits after you are determined to be an eligible survivor.

Surviving Family Members

Surviving Family Members After 1/1/2020
Surviving Family Members have up to 30 days after the date of passing to elect Survivor benefits from The Trust. Surviving Family Members are eligible for the same medical, dental, and vision plans offered to the Member. A Surviving Family Member must elect the benefit(s) (medical, dental, or vision) they want to continue as a Survivor and they can change plans during the eligibility window. However, if a Survivor does not elect a benefit at the time of retirement or later drops a benefit, they cannot re-enroll in The Trust's plans later. Surviving Spouses are allowed to add eligible dependent children to their plan following a Qualified Life Event (QLE) or during an annual open enrollment period. Surviving Spouses cannot add future eligible spouses to the plan.

Surviving Family Members prior to 12/31/2019
Surviving Family Members could elect any medical, dental, or vision benefits from The Trust for the 2020 plan year as part of a one-time re-enrollment opportunity during the 2019 open enrollment period. If a Surviving Family Member did not take a benefit during this window or later drops a benefit, they cannot re-enroll in The Trust's plan later. If a Surviving Spouse did re-enroll in the Trust, they can add eligible dependent children to their plan following a Qualified Life Event (QLE) or during an annual open enrollment period. Surviving Spouses cannot add future eligible spouses to the plan.

Continuing Family Members

Continuing Family Members are eligible spouses and children of Retirees who are age 65 or older and enrolled in Medicare. In this scenario, Retirees over the age of 65 can choose to enroll in Medicare and the eligible spouse and children under the age of 65 can remain enrolled in The Trust's plan. The eligible Retiree and spouse must both be enrolled in the benefit prior to the Retiree reaching the age of 65 to qualify for Continuing Family Member status. Continuing Spouses can add eligible dependent children following a Qualified Life Event (QLE) or during an annual open enrollment period.

Note: Continuing Family Member eligibility only applies to the Medical plan. An Eligible Retiree would need to remain enrolled in a dental or vision plan for spouse and children to be covered.

Spouses and Children cannot be enrolled by themselves in JPOFFHIT coverage for any other reason other than as a Survivor or as a Continuing family member. If a retiree elects to cancel their JPOFFHIT plans, then the plan eligibility ends for all family members.

APPENDIX D

Eligible Dependents

Your eligible dependents include:

- your legal spouse;
- your child under the age of 26

For purposes of the Plan, your child includes:

- your biological child;
- your legally adopted child (including any child lawfully placed for adoption with you);
- your stepchild;
- a foster child who has been placed with you by an authorized placement agency or by judgment decree or other court order;
- a child for whom you are the court-appointed legal guardian;
- an eligible child for whom you are required to provide coverage under the terms of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN).

Overage Dependents

A dependent child can remain on the medical and prescription drug plan from the age of 26 through the end of the month in which they turn 30 if they meet the following criteria:

- Is unmarried
- Has no dependents of their own
- Is dependent on employee for financial support
- Is not offered coverage through another group or individual plan
- Is not entitled to benefits under Title XVIII of Social Security Act
- Is either a resident of Florida or a full or part-time student living outside the state of Florida

NOTE: Under Florida Statute § 627.6562(3), if a child is provided coverage under your policy after the end of the calendar year in which the child reaches age 25 and coverage for the child is subsequently terminated, the child is not eligible to be covered under your policy unless the child was continuously covered by other creditable coverage without a gap in coverage of more than 63 days.

You are required to complete an affidavit within 30 days of your dependent turning 26. You will then be required to resubmit an affidavit every year during open enrollment to confirm eligibility for the next plan year. Failure to complete the affidavit(s) will result in termination of the child's coverage. Coverage will end on the last day of the month in which the child turns 26.

Disabled Dependents

A disabled dependent can remain on the Benefit Program(s) shown in Appendix A or Appendix B. You are required to provide documentation to the Plan proving your child's disabled status before the child reaches age 26. For purposes of the Plan, a disabled dependent includes:

- an unmarried child of any age who is not capable of self-support due to a physical or mental disability that occurred before age 26, whose disability is continuous, and who is principally supported by you.

Grandchildren

You can enroll the child of your dependent child (grandchildren) in the medical and prescription drug plan for up to 18 months of age. Your dependent child must be under the age of 26 and enrolled in the medical and prescription drug plan prior to enrolling the grandchild. Coverage will end at the end of the month in which the grandchild turns 18 months.

It is your responsibility to notify the Trust if your dependent becomes ineligible for coverage or otherwise has a status change that affects their eligibility for the Plan.

The Trust reserves the right to verify that your dependent is eligible or continues to be eligible for coverage under the Plan's Benefit Programs. To ensure that coverage for an eligible dependent continues without interruption, you must submit the required proof within the designated time period. If you fail to do so, coverage for your dependent may be canceled.