

ELIGIBILITY FOR PARTICIPATION

Employee Eligibility

A full-time Employee of the Employer who regularly works 30 Hours of Service per week or a part-time Employee of the Employer who regularly works 15 or more Hours of Service per week will be eligible to enroll for coverage under this Plan as of the date he/she completes at least one Hour of Service with the Employer. Includes Seasonal Employees.

Participation in the Plan will begin as of the first day of the month following the date he or she completes at least one Hour of Service with the Employer provided all required election and enrollment forms are properly submitted to the Plan Administrator.

You are not eligible to participate in the Plan if you are a temporary Employee, a student clerk, an Individual proprietor, civilian volunteer, partner, an independent contractor or subcontractor or a person performing services pursuant to a contract under which you are designated an independent contractor (regardless of whether you might later be deemed a common law employee by a court or governmental agency).

Dependent Eligibility* – only applies to Full-time Employees

NOTE: Part-time Employees are not eligible for Dependent coverage.

* Refer to the "Extended Coverage for Dependents Ages 26-30" section of the Plan for additional information.

Your Dependents are eligible for participation in this Plan provided he/she is:

- (1) Your Spouse.
- (2) Your Child until the end of the month in which he/she attains age 26.
- (3) Your Child age 26 or older, who is unable to be self supporting by reason of mental or physical handicap and is incapacitated, provided the Child suffered such incapacity prior to the end of the month in which he/she attained age 26. Your Child must be unmarried and primarily dependent upon you for support. The Plan Sponsor may require subsequent proof of your Child's disability and dependency, including a Physician's statement certifying your Child's physical or mental incapacity.
- (4) A newborn of your Dependent Child from birth until the end of the 18th month after birth.
- (5) A Child for whom you are required to provide health coverage due to a Qualified Medical Child Support Order (QMCSO). Procedures for determining a QMCSO may be obtained from the Plan Administrator at no cost.

The below terms have the following meanings:

"Child" means your natural born son, daughter, stepson, stepdaughter, legally adopted Child (or a Child placed with you in anticipation of adoption), Eligible Foster Child or a Child for whom you are the Legal Guardian. Coverage for an Eligible Foster Child or a Child for whom you are the Legal Guardian will remain in effect until such Child no longer meets the age requirements of an eligible Dependent under the terms of the Plan, regardless of whether or not such Child has attained age 18 (or any other applicable age of emancipation of minors).

"Child placed with you in anticipation of adoption" means a Child that you intend to adopt, whether or not the adoption has become final, who would otherwise be eligible for enrollment if the Child was your natural born Child. The term "placed" means the assumption and retention by you of a legal obligation for total or partial support of the Child in anticipation of adoption of the Child. The Child must be available for adoption and the legal process must have commenced.

"Eligible Foster Child" shall mean an individual who is placed with you by an authorized placement agency.

"Legal Guardian" means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of an individual that is placed with such person by judgment, decree or other order of any court of competent jurisdiction.

“Spouse” means any person who is lawfully married to you under any state law. Specifically excluded from this definition is a Spouse by reason of common law marriage, whether or not permitted in your state. The Plan Administrator may require documentation proving a legal marital relationship.

The Plan Administrator, in its sole discretion, shall have the right to require documentation necessary to establish an individual's status as an eligible Dependent.

When you and your Spouse are both Covered Employees

When both you and your Spouse are covered Employees, each of you must choose coverage as either an Employee or as a Dependent for each type of coverage (Medical/Vision and Dental). An Employee who is also the Spouse of an Employee may be covered as an Employee under Medical/Vision and a Dependent under Dental, or as an Employee under Dental and a Dependent under Medical/Vision.

Extended Coverage for Retirees & Spouses of Deceased Retirees

A full or part-time Employee, who retires in accordance with Florida Statutes 112.0801 and 121.021, may elect to continue Plan coverage without interruption. Eligible Dependents of a Retiree may also have continued coverage. A Retiree may select a lower Plan level within 31 days of retirement. Coverage must be elected at the time of retirement. If coverage is not elected at the time of separation from the agency, the Retiree is not eligible to again elect coverage if there has been an interruption in coverage.

The Retiree will be required to contribute to the Plan at rates equal to the full cost of coverage for a Covered Person and the full cost of coverage for Dependents – unless there is a qualifying contribution from the Employer. Contributions must be kept current in order for coverage to remain in effect. The requirements for timely payment are the same as those applied to COBRA participants. Payment is due the first day of the month of coverage.

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A covered Retiree may make appropriate changes during the extension of coverage period if Dependents are acquired or lost (i.e. marriage, divorce, annulment, birth of a child, or adoption or placement of a child for adoption). The Retiree must complete a Change of Status form within 60 days after the event, or within 60 days in the case of a divorce or annulment. Required documentation of the change must be submitted with the Change of Status form to the Plan Administrator. The effective date of the coverage change will be the date of the event, in the case of adding Dependents. In the case of a divorce or annulment, coverage will extend to the last day of the month of the event

If a Retiree qualifies for Medicare and decides not to participate in the Plan or if a Retiree dies, his or her Spouse may continue extended coverage hereunder, but must pay the required contributions.

Eligible Retirees may elect coverage under the Plan as a secondary coverage to Medicare, coverage under a new Employer, or any other coverage. The eligible Retiree will pay the full amount of the premium. Any other coverage would follow the guidelines for order of benefits.

Retirees who, upon retirement, are married to a member with coverage can elect to stay covered under the Spouse's (member's) coverage. Should the member terminate employment prior to being eligible to continue coverage as a Retiree as defined by FS 112.0801 and FS 121.021, the Retiree (the member's Spouse) can then pick up coverage as a Retiree as long as there has been no interruption in coverage under the Plan since their retirement. The Plan Administrator will provide guidance for members who terminate from the agency under these circumstances.

If at any point you voluntarily terminate coverage, Retiree coverage would not be offered again unless there is a minimum of 4 years commitment to employment. However, if you are rehired as a full-time or part-time Employee and you maintain continuous coverage, the 4 year minimum requirement is waived.

Court Ordered Coverage for a Child

Federal law requires the Plan, under certain circumstances, to provide coverage for your Children. The details of these requirements are summarized below.

The Plan Administrator shall enroll for immediate coverage under this Plan any Child, who is the subject of a "qualified medical child support order" ("QMCSO"). If you are ordered to provide such coverage for a Child and you are not enrolled in the Plan at the time the Plan Administrator receives a QMCSO, the Plan Administrator shall also enroll you for immediate coverage under this Plan. Coverage under the Plan will be effective as of the later of the date specified in the order or the date the Plan Administrator determines that the order is a QMCSO. Any required contribution for coverage pursuant to this section will be deducted from your pay in accordance with the Employer's payroll schedule and policies.

A QMCSO is defined as a child support decree or order issued by a court (or a state administrative agency that has the force and effect of law under applicable state law) that obligates you to support or provide health care coverage to your Child and includes certain information concerning such coverage. The Plan Administrator will determine whether any child support order it receives constitutes a QMCSO. Except for QMCSO's, no child is eligible for Plan coverage, even if you are required to provide coverage for that Child under the terms of a separation agreement or court order, unless the Child is an eligible Child under this Plan. Procedures for determining a QMCSO may be obtained, free of charge, by contacting the Plan Administrator.

Timely Enrollment

Once you are eligible to participate in the Plan, you must enroll for coverage by completing all election and enrollment forms and submitting them to the Plan Administrator within 60 days after satisfaction of the eligibility requirements. If you are required to contribute towards the cost of coverage you must complete and submit a payroll deduction authorization for the Plan Administrator to deduct the required contribution from your pay. In addition, as part of the enrollment requirements, you will be required to provide a marriage certificate to add a Spouse and birth certificates to add any Children as Dependents. You will also be required to provide your social security number as well as the social security number of any of your covered Dependents. Upon enrollment, you will be required to provide copies of the social security cards, reflecting the correct social security number and correct name on each card. The Plan Administrator may request this information at any time for continued eligibility under the Plan. Failure to provide the required social security numbers may result in loss of eligibility or loss of continued eligibility under the Plan.

If you decline enrollment for you and/or your Dependents, you must provide a written statement to the Plan Administrator indicating that the reason you are declining enrollment is due to other health coverage. If you lose such other health coverage, it may constitute a Special Enrollment Event (described below) that gives you and/or your Dependents a right to enroll in the Plan mid-year due to such loss of coverage. However, if you failed to submit such written statement when initially eligible, you will lose your right to this special mid-year enrollment opportunity.

Upon hire and during the open enrollment period, any employee that chooses to waive coverage in the Plan must complete and submit the Declination of Coverage form. Annual completion is required.

If you fail to complete and submit the appropriate election and enrollment forms within the 60-day period described above, you will not be eligible to enroll in the Plan until the next open enrollment period or unless you experience a Special Enrollment Event or a Status Change Event.

Open Enrollment Period

You and your Dependents may enroll for coverage during the Plan's open enrollment period, designated by the Plan Sponsor and communicated to you prior to such open enrollment period, provided all required election and enrollment forms are properly submitted to the Plan Administrator. During this time you will be permitted to make changes to any existing benefit elections. Benefit elections made during the open enrollment period will be effective as of January 1 and will remain in effect until the next open enrollment period unless you experience or your Dependent experiences a Special Enrollment Event or Status Change Event. During open enrollment, certified court divorce decrees and/or official annulment documents are not required to remove a Spouse from coverage.

Upon hire and during the open enrollment period, any employee that chooses to waive coverage in the Plan must complete and submit the Declination of Coverage form. Annual completion is required.

NOTE: You are required to properly complete and submit all required election and enrollment forms to the Plan Administrator. If you do not submit the required election and enrollment forms to the Plan Administrator during the open enrollment period it will be assumed you have decided not to participate in the Plan, and you will not have the opportunity to enroll until the next annual open enrollment period unless you experience a Special Enrollment Event or a Status Change Event.

Late Enrollment

If you did not enroll during your original 60-day eligibility period you may do so by making written application to the Plan Administrator during the annual open enrollment period (refer to annual open enrollment period section above). In these circumstances, you and/or your eligible Dependents will be considered Late Enrollees.

Special Enrollment Event

A special enrollment event occurs when you or your Dependents suffer a loss of other health care coverage, when you become eligible for a state premium assistance subsidy or acquire a new Dependent as a result of marriage, birth, adoption or placement for adoption. In these circumstances, you and/or your eligible Dependents will be considered Special Enrollees.

Each special enrollment event is more fully described below:

- (1) **Loss of Other Coverage (other than under Medicaid or SCHIP).** If you declined enrollment for yourself or your Dependents (including your Spouse) because you or your Dependents had other health coverage (including coverage under a group health plan sponsored by a governmental or educational institution, a medical care program of the Indian Health Service or of a tribal organization), you may enroll for coverage for yourself and/or your Dependents under this Plan if the other health coverage is lost as a result of one of the following provided, however, you submitted a written statement to the Plan Administrator when you and/or your Dependents were initially eligible stating that other health coverage was the reason for declining enrollment under this Plan:
 - (a) The other health coverage was under COBRA and the maximum continuation period available under COBRA has been exhausted;
 - (b) Loss of eligibility under the other health coverage for reasons other than non-payment of the required contribution or premium, making a fraudulent claim or intentional misrepresentation of a material fact in connection with the other plan; or
 - (c) Employer contributions cease for the other health coverage.

If you are already enrolled in a benefit option available under the Plan and your Dependent lost his or her other health coverage, you may enroll in a different benefit option available under the Plan due to the special enrollment event of your Dependent. The Special Enrollment Event is only for the individual who was affected by the event. Adding other family members to the Plan who are not currently covered is not allowed until open enrollment. You will need to provide proof of loss of prior coverage before your Dependent can be added to the Plan under the Special Enrollment Event.

You must submit the appropriate election and enrollment forms and supporting proof of loss of coverage to the Plan Administrator within 60 days after the date the other health coverage was lost. Coverage under the Plan will become effective on the first day of the month following the date of the Special Enrollment Event.

- (2) **Loss of Coverage under Medicaid or SCHIP or Eligibility for a State Premium Assistance Subsidy.** If you or your Dependents did not enroll in the Plan when initially eligible because you and/or your Dependents were covered under Medicaid or a state sponsored Children's Health Insurance Program (SCHIP) and your coverage terminates because you or your Dependents are no longer eligible for Medicaid or SCHIP or you or your Dependents become eligible for a state premium assistance subsidy under Medicaid or SCHIP, you may enroll for coverage under this Plan for yourself and your Dependents after Medicaid or SCHIP coverage terminates or after you or your Dependents' eligibility for a state assistance subsidy under Medicaid or SCHIP is determined.

You must submit the appropriate election and enrollment forms to the Plan Administrator within 60 days after coverage under Medicaid or SCHIP terminates or within 60 days after eligibility for a state premium assistance subsidy under Medicaid or SCHIP is determined. Coverage under the Plan will become effective on the first day of the month following the date you submit the appropriate election and enrollment forms to the Plan Administrator.

- (3) **Acquisition of a New Dependent.** If you acquire a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll for coverage under this Plan for yourself and your Dependents. You must submit the appropriate election and enrollment forms to the Plan Administrator within 60 days after the date you acquire such Dependent.
- (a) Coverage becomes effective for a Dependent Child who is born after the date your coverage becomes effective as of such Child's date of birth provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 60 days after the Child's birth. Failure to enroll in the Plan within this 60-day period will result in no coverage under the Plan.
 - (b) Coverage for a newly acquired Dependent due to marriage will be effective on the date of marriage provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 60 days after your date of marriage. Failure to enroll in the Plan within the 60-day period described above will result in no coverage under the Plan.
 - (c) Coverage for a newly acquired Dependent due to adoption (or placement with you in anticipation of adoption) will be effective as of the date of adoption (or placement in anticipation of adoption) provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 60 days after adoption or placement in anticipation of adoption, as applicable. Failure to enroll in the Plan within the 60-day period described above will result in no coverage under the Plan until an Open Enrollment Period.

Status Change Event

Generally your election under the Plan will remain in effect for the entire Plan Year unless you experience a Special Enrollment Event (described above) or a Status Change Event. If a Status Change Event occurs you may make a new election under the Plan provided your new election is consistent with the Status Change Event. A Status Change Event includes the following:

- (1) A change in your legal marital status, including divorce, or annulment;
- (2) The death of your Spouse or Dependent Child;
- (3) Termination or commencement of employment by you, your Spouse or your Dependent Child that results in the gain or loss of eligibility under the Plan or another employer-sponsored employee benefit plan;
- (4) A reduction or increase in your hours of employment or those of your Spouse or your Dependent Child, including a switch from part-time to full-time or commencement or return from an unpaid Leave of Absence, resulting in the gain or loss of eligibility under the Plan or another employer-sponsored employee benefit plan;
- (5) A change due to your Dependent Child satisfying or ceasing to satisfy the requirements for Dependents under the Plan;
- (6) Entitlement to or loss of entitlement to Medicare or Medicaid by you, your Spouse or your Dependent Child;
- (7) Receipt of a Qualified Medical Child Support Order ("QMCSO") which requires that you provide the Child named in the Order with health care coverage under the Plan. If the required coverage is different from your current coverage under the Plan, you may change your election accordingly;
- (8) A change due to you, your Spouse or your Dependent Child gaining coverage under another employer's plan;
- (9) A significant increase in the cost of your coverage under the Plan during the Plan Year. If the cost of your coverage under the Plan significantly increases during the Plan Year, you may choose one of the following options: (a) maintain existing coverage and agree to pay the increased cost; (b) revoke your existing election and elect similar coverage under another Plan option (if any); or (c) drop coverage under the Plan, but only if there is no similar option available under the Plan;

- (10) Addition or significant improvement of a Plan option. If the Plan adds a new option or significantly improves an existing option, you may revoke your existing election and elect coverage under the new option. Any eligible Employee, regardless of whether or not he/she elected coverage under the Plan previously, may elect coverage under any new option or significantly improved option for himself or herself and any eligible Dependents;
- (11) Significant Curtailment of Coverage without Loss. If your coverage under the Plan is significantly curtailed without a loss of coverage (for example, a significant increase in the Out-of-Pocket maximum you are required to pay), you may revoke your existing election under the Plan and elect coverage under a similar Plan option, if any. If no similar option is available, then you must maintain your existing election until the end of the current Plan Year;
- (12) Significant Curtailment of Coverage with Loss. If your coverage under the Plan is significantly curtailed with a loss of coverage (for example, elimination of a benefit option under the Plan), then you may either revoke your existing election under the Plan and elect coverage under a similar Plan option (if any) or drop your existing coverage provided there is no similar Plan option available; and
- (13) Change in Election under another Employer Plan. You may make an election change that is on account of and corresponds with a change made under another employer-sponsored plan (including another plan maintained by the Employer or a plan maintained by the employer of your Spouse or Dependent Child) provided the election change satisfied the regulations under Code Section 125 regarding permitted election changes or the election is for a period of coverage under the plan maintained by the other employer which does not correspond to the Plan Year of this Plan.

You must submit the appropriate election and enrollment forms, and supporting proof of Status Change Event to the Plan Administrator within 60 days after the Status Change Event to add a Dependent or Spouse. Coverage under the Plan will become effective on the date of the Status Change. Supporting proof of new coverage must be available upon request.

You must submit the appropriate election, to the Plan Administrator within 60 days after the Status Change Event to remove a Dependent or Spouse from the Plan.

If the Status Change Event is a change in your legal marital status resulting from a divorce, or annulment, you must provide a completed Change of Status form with a copy of the verified court divorce decree, and/or official annulment documents to the Plan Administrator within 60 days of the date of the event. Coverage will be effective through the last day of the month of the event.