

# HEALTH REIMBURSEMENT ARRANGEMENT

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SUMMARY PLAN DESCRIPTION

FOR

ALL CHILDREN'S HEALTH SYSTEM, INC.

# TABLE OF CONTENTS

## *INTRODUCTION....1*

### *ELIGIBILITY....1*

1. **What Are the Eligibility Requirements for Our Plan?** ..... Error! Bookmark not defined.
2. **When is My Entry Date?** ..... Error! Bookmark not defined.
3. **Are There Any Employees Who Are Not Eligible?** ..... Error! Bookmark not defined.

### *BENEFITS...ERROR! BOOKMARK NOT DEFINED.*

1. **What Benefits Are Available?**..... Error! Bookmark not defined.
2. **When Must Expenses Be Incurred?** ..... Error! Bookmark not defined.
3. **When Will I Receive Payments From The Plan?** ..... Error! Bookmark not defined.
4. **What Happens If I Terminate Employment?**..... Error! Bookmark not defined.
5. **Uniformed Services Employment and Reemployment Rights Act (USERRA)**..... Error! Bookmark not defined.

### *GENERAL INFORMATION ABOUT OUR PLAN....4*

1. **General Plan Information** ..... Error! Bookmark not defined.
2. **Employer Information**..... Error! Bookmark not defined.
3. **Plan Administrator Information** ..... Error! Bookmark not defined.
4. **Third Party Claims Administrator Information**..... Error! Bookmark not defined.
5. **Service of Legal Process** ..... **5**
6. **Type of Administration** ..... **5**

### *ADDITIONAL PLAN INFORMATION....5*

1. **Your Rights Under ERISA** ..... Error! Bookmark not defined.
2. **How to Submit a Claim** ..... Error! Bookmark not defined.

# **HEALTH REIMBURSEMENT ARRANGEMENT**

## **INTRODUCTION**

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

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

## **I ELIGIBILITY**

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

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

### **2. When is My Entry Date?**

You can join the Plan on the day you meet the eligibility requirements.

### **3. Are There Any Employees Who Are Not Eligible?**

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

-- Employees who are not enrolled in the Cigna CDP group medical plan.

## **II BENEFITS**

### **1. What Benefits Are Available?**

The plan allows you to be reimbursed for certain out-of-pocket medical, dental and vision expenses which are incurred by you and your dependents. The expenses which qualify are those permitted by Section 213 of the Internal Revenue Code. Prescription expenses are not eligible for reimbursement. A list of some of the expenses that qualify is available from the Administrator.

The maximum allowed each year is \$600 per participant up to \$1,200 per family.

Expenses are considered “incurred” when the service is performed, not necessarily when it is paid for. Any amounts reimbursed to you under the Plan may not be claimed as a deduction on your personal income tax return nor reimbursed by other health plan coverage including our health flexible spending account.

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

You may submit expenses that you incur each “Coverage Period.” A new “Coverage Period” begins each calendar year.

**3. When Will I Receive Payments From The Plan?**

During the course of the Coverage Period, you may submit requests for reimbursement of expenses you have incurred. However, you must make your requests for reimbursements no later than 90 days after the end of the Coverage Period. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. In addition, you must submit to the Administrator proof of the expenses you have incurred and that they have not been paid by any other health plan coverage. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, reimbursements made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes.

**4. What Happens If I Terminate Employment?**

If your employment is terminated during the Plan Year for any reason, your participation in the Plan will cease and any unused amounts are forfeited. You must make your requests for reimbursements no later than 90 days after the end of the Coverage Period

Under Federal law, if you lose coverage under this Plan, then you may be entitled to continuation of health care coverage. The Administrator will inform you of these rights if you lose coverage. Generally, if we (and any related companies) employed twenty (20) or more employees “on a typical business day” in the preceding calendar year, health plan continuation must be made available.

If you, your Spouse, or your Dependent children incur an event known as a “Qualifying Event,” and if such individual is covered under the HRA Plan when the Qualifying Event occurs, then the individual incurring the Qualifying Event will be entitled under COBRA (except in the case of certain small employers) to elect to continue his or her coverage under the HRA Plan if he or she pays the applicable premium for such coverage. “Qualifying Events” are certain types of events that would cause, except for the application of COBRA's rules, an individual to lose his or her health insurance coverage.

A Qualifying Event includes the following events:

- Your termination from employment or reduction of hours;
- Your divorce or legal separation from your Spouse;
- Your becoming eligible to receive Medicare benefits;

- Your Dependent child's ceasing to qualify as a Dependent.

Under certain circumstances, persons who are disabled at the time of termination of employment or reduction in hours and/or within the first 60 days of COBRA coverage may be eligible for continuation of coverage for a total of 29 months (rather than 18). You should check with the Administrator for more details regarding this extended coverage.

Plan continuation must be made available for a maximum period of 18 months, if the reason coverage ends is either termination of your employment or a reduction in hours of employment that makes you ineligible to participate in the HRA plan. However, in certain circumstances, this continuation coverage may be terminated for reasons such as failure to pay continuation coverage cost, termination of our HRA plan, or a “for cause” termination of coverage for reasons such as fraud.

If the Qualifying Event is termination from employment, then the COBRA continuation coverage runs for a period of 18 months following the date that regular coverage ended. COBRA continuation coverage may be extended to 36 months if another Qualifying Event occurs during the initial 18-month period. You are responsible for informing the Administrator of the second Qualifying Event within 60 days after the second Qualifying Event occurs. COBRA continuation coverage may also be extended to 29 months in the case of an individual, disabled within 60 days after the date the entitlement to COBRA continuation coverage initially arose and who continues to be disabled at the end of the 18 months. In all other cases to which COBRA applies, COBRA continuation coverage shall be for a period of 36 months.

## **5. Family and Medical Leave Act (FMLA)**

If you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections for health insurance. If your coverage in these benefits terminates, due to your revocation of the benefit while on leave or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return.

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

## **6. Uniformed Services Employment and Reemployment Rights Act (USERRA)**

If you are going into or returning from military service, you may have special rights to health care coverage under your Direct Reimbursement Arrangement under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask your Administrator for further details.

### **III**

## **GENERAL INFORMATION ABOUT OUR PLAN**

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

### **1. General Plan Information**

All Children's Health System, Inc. Health Reimbursement Plan is the name of the Plan.

Your Employer has assigned Plan Number 511 to your Plan.

The provisions of your Plan become effective on January 1, 2017.

### **2. Employer Information**

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

All Children's Health System, Inc.  
501 Sixth Street South  
St. Petersburg, FL 33701  
59-2481740

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

### **3. Plan Administrator Information**

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

All Children's Health System, Inc.  
501 Sixth Street South  
St. Petersburg, FL 33701  
727-898-7451

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

#### **4. Third Party Claims Administrator Information**

The name, address and business telephone number of the Third Party Claims Administrator are:

Allegiance Benefit Plan Management, Inc.  
P. O. Box 4346  
Missoula, MT 59806  
(406) 721-2222 or (877) 424-3570

The Third Party Claims Administrator is responsible for the actual processing of claims on behalf of the Plan Administrator.

#### **5. Service of Legal Process**

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

#### **6. Type of Administration**

The Plan is a health reimbursement arrangement and the administration is provided through a Third Party Claims Administrator. The Plan is not funded or insured. Benefits are paid from the general assets of the Employer.

### **IV ADDITIONAL PLAN INFORMATION**

#### **1. Your Rights Under ERISA**

Plan Participants, eligible employees and all other employees of the Employer may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. These laws provide that Participants, eligible employees and all other employees are entitled to:

- (a) examine, without charge, at the Administrator's office, all Plan documents, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.
- (b) obtain copies of all Plan documents and other Plan information upon written request to the Administrator. The Administrator may charge a reasonable fee for the copies.
- (c) Continue health care coverage for a Plan Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents may have to pay for such coverage.

- (d) Review this summary plan description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the best interest of you and other Plan Participants.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

In addition, if a Plan Participant disagrees with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.



If you have any questions about the Plan, you should contact the Administrator. If you have any questions about this statement, or about your rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA) or if you need assistance in obtaining documents from the Administrator, you should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at [www.dol.gov/ebsa/](http://www.dol.gov/ebsa/). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## 2. How to Submit a Claim

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

- (1) Obtain a claim form from the Plan Administrator.
- (2) Complete the Employee portion of the form.
- (3) Attach copies of all bills from the service provider for which you are requesting reimbursement.

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

Notification of whether Claim is accepted or denied	30 days
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Extension due to matters beyond the control of the Plan	15 days
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Insufficient information on the Claim:

Notification of	15 days
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Response by Participant	45 days
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Review of Claim denial	60 days
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The Plan Administrator will provide written or electronic notification of any Claim denial. The notice will state:

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

- (2) Reference to the specific Plan provisions on which the denial was based.
- (3) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.
- (4) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the your right to bring a civil action under Section 502 of ERISA following a denial on review.
- (5) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim; and
- (6) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

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

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

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

- (1) was relied upon in making the Claim determination;
- (2) was submitted, considered, or generated in the course of making the Claim determination, without regard to whether it was relied upon in making the Claim determination;
- (3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that Claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants;
- (4) or constituted a statement of policy or guidance with respect to the Plan concerning the denied Claim.

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

ملحوظة: اذا كنت تتحدث ذاكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 855-999-1063 (رقم هاتف الصم او لبيكم: 855-999-1062).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-999-1062 (TTY : 1-855-999-1063)

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-999-1062 (TTY: 1-855-999-1063).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-999-1062 (TTY: 1-855-999-1063).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-999-1062 (ATS : 1-855-999-1063).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-999-1062 (TTY: 1-855-999-1063).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-999-1062 (TTY: 1-855-999-1063).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。  
1-855-999-1062 (TTY:1-855-999-1063) まで、お電話にてご連絡ください。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-999-1062 (TTY: 1-855-999-1063)번으로 전화해 주십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-999-1062 (TTY: 1-855-999-1063).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-999-1062 (TTY: 1-855-999-1063).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-999-1062 (телетайп: 1-855-999-1063).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-999-1062 (TTY: 1-855-999-1063).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-999-1062 (TTY: 1-855-999-1063).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-999-1062 (TTY: 1-855-999-1063).