BENEFIT YEAR 2023

MERP SUMMARY

INSURANCE AND REIMBURSEMENT PLANS

SPC HUMAN RESOURCES

ST. PETERSBURG COLLEGE

"INSURANCE AND REIMBURSEMENT PLANS"

MEDICAL INSURANCE

DENTAL INSURANCE

VISION REIMBURSEMENT PLAN

CANCER AND DREAD DISEASE REIMBURSEMENT PLAN

AMENDED AND RESTATED AS OF
JANUARY 1, 2023 THROUGH DECEMBER 31, 2023

ST. PETERSBURG COLLEGE
INSURANCE AND REIMBURSEMENT PLANS

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ST. PETERSBURG COLLEGE
INSURANCE AND MEDICAL REIMBURSEMENT PLANS

The Board of Trustees of St. Petersburg College of St. Petersburg, Florida, herein referred to as the "Employer," does hereby establish a Health Insurance Program for the benefit of Eligible Employees, Retired Employees and eligible Dependents on the terms and conditions described hereinafter.

WHEREAS, the Employer currently maintains a Health Insurance Program which consists of group medical insurance; and

WHEREAS, the Employer currently maintains a Dental Insurance Program which consists of group dental insurance; and

WHEREAS, the Employer wants to maintain a self-funded vision reimbursement arrangement to reimburse Eligible Employees for certain out-of-pocket medical expenses; and

WHEREAS, the Employer wants to maintain a self-funded cancer and dread disease reimbursement arrangement to reimburse Eligible Employees for certain out-of-pocket medical expenses incurred due to cancer or dread disease; and

WHEREAS, the Employer desires to provide the vision reimbursement program, cancer, dread disease reimbursement program and group medical and dental insurance benefits under a single plan, such plan being amended and restated as of January 1, 2019.

NOW, THEREFORE, this Plan is hereby amended to read as follows:

ARTICLE I

EFFECTIVE DATE AND PURPOSE

Effective Date

The Plan is amended and restated as of January 1, 2019.

Purpose of Plan

The purpose of the Plan is to provide Vision Reimbursement Benefits, Cancer and Dread Disease Reimbursement Benefits to Eligible Employees of the Employer in accordance with Code Section 105(h), as well as employer-provided group medical and dental coverage in accordance with Code Sections 105(b) and 106.

ARTICLE II

DEFINITIONS FOR THE MEDICAL EXPENSE REIMBURSEMENT PLAN FOR CANCER/DREAD DISEASE

Annual Open Enrollment Period shall mean a 30-day period during the fall, as designated by the Employer, during which Employees may enroll themselves and their eligible Dependents in the Medical Insurance Plan.

Benefit Administration Manager shall mean the person providing services in connection with operation of the Plan, including the processing and payment of claims, as may be delegated from time to time.

Board shall mean the Board of Trustees of the Employer.

Cancer shall mean leukemia, Hodgkin's Disease, or any form of malignant growth which is positively identified as cancer (malignant neoplasm) by a licensed Doctor of Medicine or Osteopathy, other than the Participant, based on bioptic (biopsy) examination performed by a recognized, licensed Pathologist. The doctor's report must indicate the cancer or dread disease is "active" in order for the participant to be reimbursed. An updated "Claim Form," indicating the cancer/dread disease is still "active" is required every twelve (12) months.

Cancer and Dread Disease Reimbursement Benefit shall mean the cancer and dread disease reimbursement benefits provided to Eligible Employees, Retired Employees and their Dependents as described in Article VI.

Code shall mean the Internal Revenue Code of 1986, as amended, or as it may be amended from time to time.

Committee shall mean the Insurance Committee.

Dental Insurance Program shall mean the group dental insurance coverage which is made available to Eligible Employees, Retired Employees and their Dependents, as described in Article IV.

Dependent for the Vision Reimbursement Benefit shall mean the spouse of the Employee, the domestic partner of the Employee, and a natural, foster, step, legally adopted, or proposed adoptive dependent child of the Employee who is under 26. The age 26 limit shall not apply if the unmarried natural, foster, step, legally adopted, or proposed adoptive child is chiefly dependent upon the Employee for support and maintenance but is incapable of self-support due to a physical or mental incapacity which commenced prior to age 25.

Dependent for the Medical and Dental Insurance, or the Cancer and Dread Disease Reimbursement Benefit shall mean the spouse of the Employee, or Retiree, the domestic partner of the Employee, or Retiree, and a natural, foster, step, legally adopted, or proposed adoptive dependent child of the Employee, or Retiree, who is under age 26. The age 26 limit shall not apply if the unmarried natural, foster, step, legally adopted, or proposed adoptive child is chiefly dependent upon the Employee for support and maintenance but is incapable of self-support due to a physical or mental incapacity which commenced prior to age 25.

Dread Disease shall mean brain tumor, diphtheria, emphysema, lupus, multiple sclerosis, muscular dystrophy, Parkinson's disease, poliomyelitis, primary encephalitis, primary spinal meningitis, rabies, rheumatic fever, scarlet fever, small pox, tetanus, tuberculosis, or typhoid fever when diagnosed by a licensed Doctor of Medicine. The doctor's report must indicate the cancer or dread disease is "active" in order for the participant to be reimbursed. An updated "Claim Form," indicating the cancer/dread disease is still "active" is required every twelve (12) months.

Employee shall mean an employee of the Employer.

Employer shall mean St. Petersburg College of St. Petersburg, Florida.

Medical Insurance Program shall mean the group medical insurance coverage which is made available to Eligible Employees, Retired Employees and their Dependents, as described in Article IV.

Medical Expense Reimbursement Benefit shall mean the medical reimbursement benefits provided to Eligible Employees, Retired Employees and their Dependents as described in Articles V and VI.

Participant shall mean any Eligible Employee or Eligible Retired Employee as defined in Section III.

Pathologist shall mean a doctor who is specializes in identifying diseases by studying cells and tissues under a microscope and who is licensed by the appropriate state or federal government agency.

Plan shall mean the St. Petersburg College Health Insurance Plan, as herein set forth or as it may be duly amended.

Plan Administrator shall mean the person responsible for the functions and management of the Plan. The Plan Administrator shall be the Committee.

Plan Year shall mean the twelve-month period ending on December 31 of each year. The Plan Year shall be the period of coverage for each benefit hereunder.

Qualified Medical Child Support Order shall mean a medical child support order which creates or recognizes a child's right to receive benefits for which an Employee or beneficiary is eligible to receive under the Plan. A medical child support order shall be deemed to be a Qualified Medical Child Support Order (QMCSO) if it conforms to the requirements of the model and procedures specified under regulations.

A medical child support order shall not be considered a Qualified Medical Child Support Order if such order requires the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to child support described in Section 1908 of the Social Security Act.

Retired Employee shall mean an employee who has retired under the terms of the Employer's retirement plan and who is receiving a monthly pension benefit through either the Florida Retirement System or the Community College Optional Retirement Plan (CCORP).

ARTICLE III

PARTICIPATION IN THE PLAN

Eligible Employees

An Employee who works in a regularly established position who meets the minimum hourly requirement shall be eligible to become a Participant in the Plan on the first day of the month following completion of 30 continuous days of employment with the Employer. A regularly established position is a full-time or part-time position authorized by law and paid from a salary appropriation or account. It does not include a temporary position or a position paid from an Other Personal Services (OPS) account. The minimum hourly requirement is the number of hours the Employee must be regularly scheduled to work.

An Employee who terminates employment with St. Petersburg College, but later is rehired, will be treated as a new Employee. As a new Employee, he/she will be required to re-satisfy the Plan's eligibility provisions before coverage can begin.

Eligible Retirees

A Retired Employee shall be eligible to continue to participate in the Medical and Dental Plans beginning on his/her retirement date. The Retired Employee shall only be eligible to participate in the Medical and Dental Insurance Plans if he/she was covered under the Medical and Dental Insurance Plan on his/her date of retirement.

He/she shall only be eligible to participate in the Cancer and Dread Disease Reimbursement Benefit if he/she was enrolled in that benefit on his/her retirement date. Enrollment eligibility is based on the retiree being enrolled in the Medical Insurance Plan as of their retirement date.

A Retired Employee shall not be eligible for Vision Reimbursement Benefit.

Medicare

A Retiree who is eligible for Medicare, and who is retired from the College, must be able to document coverage under Medicare Parts A and B and a separate Medicare Supplement plan or Medicare + Choice (sometimes called Medicare C) in order to be covered for Cancer and Dread Disease Reimbursement Benefits under this Plan. The combination of Medicare coverage plus Medicare Supplement coverage must pay a minimum of 70% of the covered expenses under this Plan.

This provision does not apply to any Participant or covered Dependent for whom St. Petersburg College is required to provide medical care coverage on a primary basis with Medicare benefits payable on a secondary basis under applicable federal law.

Initial Enrollment

An Employee who is eligible to become a Participant in the Plan will be eligible for benefits under the Cancer and Dread Disease Reimbursement Plan on the date he/she becomes eligible to participate provided he/she is covered under the College's Medical and Dental Insurance Program.

An Employee who is eligible to become a Participant in the Plan may enroll in the Medical and Dental Insurance Program by completing the required enrollment form(s) within 31 days after first becoming eligible to participate in the Plan and agreeing to make any required contributions. An Employee who enrolls in the Medical Insurance Program will be eligible for benefits under the Vision Reimbursement Benefit on the date he/she enrolls in the Medical Insurance Program. An Employee who does not enroll in the Medical Insurance Program will not be eligible for benefits under the Vision Reimbursement Benefit.

An Employee who does not elect to become a Participant in the Plan when he/she first becomes eligible, may not enroll in the plan until the next Open Enrollment period unless he/she qualifies for a special enrollment or experiences a Qualifying Event Change in Status.

A Retired Employee who elects to continue Participation in the Medical and Dental Insurance Programs and the Cancer/Dread Disease Reimbursement Benefit may continue participation by agreeing to pay required premiums, on all three plans, and by completing a coverage continuation form within 31 days after his/her retirement date. In order for a Retiree to be

able to purchase the Cancer and Dread Disease Reimbursement Plan, he/she must also be enrolled in, and paying the premiums for, the College's Medical Plan. Any Retiree who does not elect continuation of coverage(s) within 31 days after his/her retirement date will not be permitted to enroll at a later date.

An Employee who does not elect to become a Participant in the Medical and/or Dental Insurance Programs when he/she first becomes eligible, may not enroll in the Program until the next Annual Open Enrollment Period unless he/she qualifies for a special enrollment or experiences a Qualifying Event.

Annual Open Enrollment Period

This shall mean a 30-day period during the fall, as designated by the Employer, during which Employees may enroll themselves and their eligible Dependents in the Medical and/or Dental Insurance Programs.

Special Enrollment

Employees and enrolled Retirees shall have the special enrollment rights required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Qualifying Event Change in Status

Eligible Employees may be permitted to revoke an existing election and make a new election for the remaining portion of the Plan Year under the Medical and Dental Insurance Programs if the revocation and new election are consistent with the qualified change in status. Qualified changes in status are:

- Events that change the Employee's legal status – marriage, divorce, death of the Employee, or annulment;
- Events that change the number of Dependents – birth, adoption, placement for adoption; or death of a Dependent;
- A change in the employment status of the Employee, spouse, domestic partner or Dependent – a reduction in hours which changes the Employee's, spouse's or domestic partner's status from full to part time or vice versa if it affects eligibility for Medical coverage under this Plan or the spouse's or domestic partner's plan or the

commencement or termination of employment if it affects eligibility for Medical coverage;

- An event that causes a Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, marriage of a Dependent child or similar events as described in the applicable insurance contracts used to fund the Health Program;
- Commencement of or return from an unpaid Leave of Absence by the Employee, spouse or domestic partner;
- Receipt by the Employee (or this Plan) of a Qualified Medical Child Support Order (QMCSO) that requires the Employee or domestic partner to provide Medical and/or dental insurance coverage for a child; or receipt of a QMCSO that requires a former spouse or domestic partner to provide Medical coverage.

Election changes must be consistent with the change in status. The Employee must notify the Plan Administrator and request a change in election within 30 days after the date of the qualified change in status. The Plan Administrator will determine if the change is a qualified change in status and what election changes are permitted.

In addition to the above, the Plan Administrator may permit changes in elections during the year if an existing health plan is eliminated or if there is a significant increase in the cost of a health plan. The Plan Administrator shall determine if and what election changes will be permitted and will notify affected Employees.

Changes approved by the Plan Administrator will become effective on the later of the date of the event or the date of the Employee's written request for a change.

Contributions

Employees and Retired Employees may be required to pay the cost of benefit coverage which they elect under the Medical Program. The Committee shall determine the required contributions and communicate this information to affected individuals prior to the beginning of the Plan Year.

Termination of Participation

Participation in the Plan shall terminate with respect to the Employees, Retirees and/or Dependents on the earliest of the following dates:

- The Plan is terminated;
- The date the Employee revokes his/her election to participate;
- The date the Employee ceases to make any required contributions;
- The date the Employee ceases to be eligible to participate in the Plan.

Coverage will terminate under the Vision Reimbursement Benefit on the date that coverage under the Medical Insurance Plan terminates. Coverage under the Cancer and Dread Disease Reimbursement Benefit shall terminate on the date the Employee is no longer covered under the College's Medical Insurance Program, or when Retiree ceases to pay the premium.

Participation in the Plan shall terminate with respect to any Dependent on the earliest of the following dates:

- The date dependent coverage under the plan is terminated;
- The date the Employee terminates his/her coverage under the Plan;
- The date the Plan is terminated;
- The date the Employee revokes his/her election for Dependent coverage;
- The date the Dependent ceases to be eligible to participate in the Plan.

Coverage under the Cancer and Dread Disease Benefit for a Dependent child who marries can continue until the day the child turns 26.

Coverage will terminate under the Vision Reimbursement Benefit on the date that coverage under the Medical Program terminates. Coverage under the Cancer and Dread Disease Reimbursement Benefit shall terminate on the date the Dependent is no longer covered under the College's Medical Insurance Program.

Coverage under the Plan may also be terminated by the Committee for cause. Termination for cause may occur if the individual makes a material misrepresentation in applying for coverage or obtaining benefits or commits a fraudulent act with respect to the Plan.

Continuation of Coverage

If a qualifying event, within the meaning of Public Service Medical Act, occurs with respect to a Participant or covered Dependent, the Committee (or its designee) shall give such individual(s) the opportunity to continue coverage, as is required by Section 300bb-1 through 300bb-8 of Subchapter XX of the Public Medical Service Act, as amended.

Leave of Absence

An Employee who is a Participant under the Plan shall be eligible to continue coverage during an approved leave of absence in accordance with the Employer's Leave of Absence policy(ies). The Employer's Leave of Absence policy(ies) are contained in Section 6Hx23-2.28 of the Board Rule.

Notwithstanding any other provision of the Plan to the contrary, in all instances the Plan shall be operated in accordance with the requirements of the Family and Medical Leave Act of 1993 (Public Law 103-3).

ARTICLE IV

BENEFITS UNDER THE MEDICAL INSURANCE PROGRAM

The terms and conditions governing eligibility for and benefits which are available under the Medical and Dental Insurance Program shall be described in the appropriate group insurance contract(s) which shall be maintained with the Plan. Benefits under the Medical and Dental Insurance Program shall be solely those provided under the group insurance contracts. Group insurance contact(s) are listed in Appendix A attached hereto.

ARTICLE V

VISION EXPENSE REIMBURSEMENT PLAN BENEFIT

Vision Expense Reimbursement Plan Benefit

A Participant or his Dependent who incurs vision expenses described in Eligible Expenses above after his/her Effective Date shall be eligible for the Vision Reimbursement Benefit provided for below.

Eligible Expenses

Eligible Expenses under the Vision Reimbursement Benefit shall mean the following: Eligible expenses for vision expenses (eye exam, glasses, contacts) shall be reimbursed up to a maximum of $175.00 per Plan Year per covered Employee. An employee may submit expenses for any family member, but the total amount reimburseable is still a maximum of $175.00 per Plan Year per covered Employee. For employees with 10 or more years of service, they are eligible for a maximum reimbursement of up to $175.00 every 12 months. For employees with less than 10 years of service, they are eligible for a maximum reimbursement of up to $175.00 every 24 months.

Medicare

Any expense that is not covered by either Medicare or by the Medicare Supplement plan, shall not be a covered expense under the Medical Reimbursement Benefit portion of this Plan. Expenses incurred under private pay contracts as defined by Medicare are also excluded under the Medical Reimbursement Benefit portion of this Plan. Expenses excluded under any Medicare + Choice plan shall not be covered expenses under the Medical Reimbursement Benefit portion of this Plan.

This provision does not apply to any Participant or covered Dependent for whom St. Petersburg College is required to provide Medical care coverage on a primary basis with Medicare benefits payable on a secondary basis under applicable federal law.

Documentation of Expenses – Vision Reimbursement Plan

A Participant who applies for reimbursement of Medical Expense Reimbursement Plan Benefits shall submit the following information to the Plan Administrator:

(a) The name of the person, organization or entity to which the medical expenses were paid,

(b) The name of the person for whom the medical expenses were incurred; and

(c) A copy of a receipt for medical expenses.

(d) A signed statement from the Participant that the medical expenses have not been reimbursed or are not reimbursable under any other Medical plan coverage, including the Medical Program, the Health Savings Account (HSA) and the Flexible Spending Account (FSA).

Maximum Benefit

The maximum benefit payable under the Medical Reimbursement Benefit and Cancer and Dread Disease Reimbursement Benefit shall be limited to the amount determined in accordance with the "Establishment of Pool" provision described in Section VII.

Submission of Claims

Claims for expenses must be submitted within 180 days of the date the expense is incurred.

Assignability

Amounts payable by the Plan may not be used to make direct payments to physicians, hospitals or other providers of services covered by the Plan.

ARTICLE VI

CANCER AND DREAD DISEASE REIMBURSEMENT BENEFIT

Grandfather clause: For participants previously diagnosed with an "active" condition/disease who are not on the college's Medical plan but already were receiving MERP reimbursements prior to July 1, 2007, those participants will be eligible to continue receiving MERP reimbursements for the duration of the illness/condition as long as it remains "active."

For employees under the Grandfather clause (see "Who's Covered"): If there is a change of any type in the benefits under your Medical plan, you are obligated to notify **Custom Benefit Services** of the change in writing. A change that reduces the benefits under the employee's Medical plan below those levels required under the sections of this document entitled "Who's Covered" operates to void the Cancer/Dread Disease Medical Expense Reimbursement Plan coverage from the date of the change.

Cancer and Dread Disease Reimbursement Benefits

A Participant or his Dependent who incurs Eligible Expenses for the treatment of Cancer or a Dread Disease while enrolled in the Cancer and Dread Disease Reimbursement benefit shall be eligible for the Cancer and Dread Disease Reimbursement Benefits provided for below. The doctor's statement must indicate the cancer or dread disease is "active" in order for the participant to be reimbursed. An updated "Claim Form," indicating the cancer/dread disease is still "active," is required every 12 months.

Eligible Expenses

Medical expenses eligible for reimbursement under the Cancer and Dread Disease Reimbursement Benefit shall be limited to:

- Flat dollar co-payments under the Medical Insurance Program up to the maximum out-of-pocket per calendar year of $1,500. The plan covers 100% of covered prescription expenses, up to the maximum lifetime reimbursement of $25,000 for

Cancer reimbursement, and $25,000 for Dread Disease reimbursement. The $25,000 lifetime maximum includes both medical and prescription expenses provided that these Participant payment obligations are for medical expenses incurred for the treatment of Cancer or Dread Disease. Reimbursement to the Participant under the Cancer and Dread Disease Reimbursement Benefit portion of the Plan is solely for expenses incurred during the "active" treatment of Cancer or other Dread Disease. Expenses for the treatment of conditions diagnosed as pre-cancerous are not covered.

Medical expenses not covered at least in part under the Medical Program and medical expenses specifically excluded by the Medical Program are not Eligible Expenses.

Preventive examinations are covered only if Cancer is diagnosed during the examination. Preventive tests are covered only if Cancer is diagnosed as a result of those tests and only the tests specifically used to diagnose Cancer are covered.

A pre-existing condition is any covered disease that is first diagnosed prior to the effective date of the participant's coverage, or within 30 days following the effective date of the participant's coverage.

Coverage for the pre-existing condition will be available on the date on which a participant completes twelve (12) consecutive months of Medical coverage under this plan.

Expenses must be incurred (medical services rendered) while the Participant, Dependent, or Retiree is covered under the College's Medical Insurance Program

Medicare

Any expense that is not covered by either Medicare or by the Medicare Supplement plan, shall not be a covered expense under the Cancer and Dread Disease Reimbursement Benefit portion of this Plan. Expenses incurred under private pay contracts as defined by Medicare are also excluded under the Cancer and Dread Disease Reimbursement Benefit portion of this Plan. Expenses excluded under any Medicare + Choice plan shall not be covered expenses under the Cancer and Dread Disease Reimbursement Benefit portion of this Plan.

This provision does not apply to any Participant or covered Dependent for whom St. Petersburg College is required to provide Medical care coverage on a primary basis with Medicare benefits payable on a secondary basis under applicable federal law.

Documentation of Expenses

A Participant who applies for reimbursement of Cancer and Dread Disease Reimbursement Benefits shall submit the following information to the Plan Administrator:

(a) The name of the person, organization or entity to which the medical expenses were paid,

(b) A copy of the Explanation of Benefits, (EOB), provided by the insurance carrier under the College's Medical Program;

(c) The name of the person for whom the medical expenses were incurred;

(d) A copy of a "walk-out" receipt for medical expenses; and

(e) A statement by the doctor stating that the cancer or dread disease is "active," which will be required every 12 months, and

(f) A statement from the Participant that the medical expenses have not been reimbursed or are not reimbursable under any other Medical plan coverage, including the College's Medical Insurance Program, Health Savings Account (HSA), or the Flexible Spending Account, FSA.

Maximum Benefit

The maximum amount payable per person, per lifetime, for reimbursement of Eligible Expenses shall be $25,000 for Dread Disease and $25,000 for Cancer. The maximum benefit payable under the Medical Reimbursement Benefit and Cancer and Dread Disease Reimbursement Benefit shall also be limited to the amount determined in accordance with the "Establishment of Pool" provision described in Section VII.

Submission of Claims

Claims for expenses must be submitted within 180 days of the date the expense is incurred.

Assignability

Amounts payable by the Plan may not be used to make direct payments to physicians, hospitals or other providers of services covered by the Plan.

ARTICLE VII

MEDICAL REIMBURSEMENT AND CANCER AND DREAD DISEASE REIMBURSEMENT BENEFITS

The following provisions apply to both the Medical Reimbursement and Cancer and Dread Disease Reimbursement Benefits.

Establishment of Pool

Prior to the commencement of the Plan Year, the Plan Administrator may in its sole discretion designate an aggregate dollar amount that it will make available for reimbursement of Eligible Expenses for Medical Reimbursement Benefits and Cancer and Dread Disease Reimbursement Benefits for the Plan Year. The amount made available shall be divided between Eligible Employees and their Dependents ("Active Pool") and Retired Employees and their Dependents ("Retiree Pool").

The amount made available in the Active Pool shall be based on a ratio, the numerator of which is the number of Active Employees and the denominator of which shall be the total number of Active Employees and Retired Employees. Likewise, the amount made available in the Retiree Pool shall be based on a ratio, the numerator of which is the number of Retired Employees and the denominator of which shall be the total number of Active Employees and Retired Employees. Each pool shall be separately maintained and shall be unfunded.

Active Employees and their Dependents shall submit claims to the Active Pool; Retired Employees and their Dependents shall submit claims to the Retiree Pool. Amounts available from the Active Pool and the Retiree Pool shall be available for reimbursement of Eligible Expenses on a "first come, first served" basis. After a pool is depleted for a Plan Year, no further Medical Reimbursement Benefits shall be payable to covered persons for such Plan Year. Any amounts remaining in the pools shall be retained by the Employer. *Notwithstanding the preceding sentences, after the commencement of the Plan Year, the Plan Administrator may designate additional amounts to be made available for reimbursement of Eligible Expenses.*

Coordination of Benefits

Amounts payable by the Plan will be coordinated with benefits payable under other plans. Other plans shall include any other plan of Medical expenses coverage under: (1) group insurance, (2) any other type of coverage for persons in a group either insured or non-insured; and (3) no-fault and traditional "fault" auto insurance required by law and provided on other than a group basis to the extent of the level of benefits required by law.

When coverage under this Plan and another plan both apply, the order in which the each of the plans will pay benefits shall be determined using the following based on the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:
   a. Secondary to the plan covering the person as a dependent; and
   b. Primary to the plan covering the person as other than a dependent;

   The benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:
   a. Covers the person as other than a dependent; and
   b. Is secondary to Medicare.

3. Except in the case of a dependent child whose parents are divorced or separated, the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

   If the other plan does not have the rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

4. In the case of a dependent child whose parents are divorced or separated:
   a. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the Medical care expenses of the child, the order of benefit determination rules specified in 3 above will apply.
   b. If there is a court decree which makes one parent financially responsible for the medical, dental or other Medical care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.
   c. If there is not such a court decree:
      - If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

      - If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest period of time will be deemed to pays its benefits first; except that:

   The benefits of a plan which covers the person as:
   a. a laid-off or retired employee
   b. or a dependent of a laid-off or retired employee

   Shall be determined after the benefits of any other plan which covers such person as:
   a. an employee who is not laid-off or retired; or
   b. a dependent of an employee who is not laid-off or retired.

If the other plan does not have a provision regarding laid-off or retired employees and, as a result, each plan determines its benefits after the other, then the above rule shall not apply.

The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation. If the other plan does not have a provision regarding right of continuation pursuant to federal or state law and, as a result, each plan determines its benefits after the other, then the above paragraph will not apply.

The Plan has the right to release or obtain any information and make or recover any payment it considers necessary in order to administer this provision.

ARTICLE VIII

GENERAL PLAN INFORMATION

General Information About the Plan

Plan Name	St. Petersburg College Medical Insurance Plan
Plan Administrator	St. Petersburg College P.O. Box 13489 St. Petersburg, FL 33731 (727) 302-6827 EIN: 59-1211489
Type of Plan	Welfare benefits plan for Medical care
Plan Year	January 1 – December 31
Plan Effective Date	Amended and restated as of January 1, 2023
Type of Administration	Group Medical Plan – Fully Insured Group Dental Plan – Fully Insured Vision Reimbursement Benefit – Self-funded and self-administered Cancer and Dread Disease Reimbursement Benefit – Self-funded and self-administered
Insurance Company Information	Florida Blue
Named Fiduciaries	Florida Blue – Group Health Plan ✓ HMO Blue care 47 ✓ PPO Blue Options 03359 ✓ PPO Blue Options 05909 ✓ HDHP HSA 03160 ✓ HDHP HSA 03161 St. Petersburg College ✓ Vision Reimbursement Benefit ✓ Cancer and Dread Disease Reimbursement Benefit

ARTICLE IX

MISCELLANEOUS

No Guarantee of Employment

Nothing in this Plan shall be construed as guaranteeing future employment to Eligible Employees. An Eligible Employee continues to be an Employee of the Employer solely at the will of the Employer.

Administration

The Insurance Committee shall be the Plan Administrator. The Plan is administered by the Plan Administrator. The Plan Administrator has discretionary authority to determine the status and rights of Participants, beneficiaries and other persons, to construe and interpret Plan terms, to make final and binding determinations as to eligibility and benefits, to prescribe administrative procedures, to gather needed information, to employ or appoint persons to help or advise in any administrative functions, to appoint investment managers and trustees, and generally to do all other things needed to operate, manage and administer the Plan. The discretionary authority granted to the Plan Administrator is intended to be sufficient to warrant deferential judicial review of the Plan Administrator's decisions pursuant to the U.S. Supreme Court's decision in Firestone Tire and Rubber Co. v. Bruch.

The Plan Administrator may adopt any rules for administration of the Plan it considers desirable, provided they do not conflict with the Plan, and may construe the Plan, correct defects, supply omissions and reconcile inconsistencies to the extent necessary to effectively administer the Plan, and such action shall be conclusive.

The Plan Administrator shall keep a record of all actions taken and shall keep all other books of account, records, and other data that may be necessary for proper administration of the Plan and shall be responsible for supplying all information and reports to Participants and to governmental agencies and others as required by law. Records of administration of the Plan shall be kept, and Participants and their beneficiaries may examine records pertaining directly to themselves.

The Plan Administrator may, on behalf of the Plan, contract for legal, actuarial, investment, advisory, medical, accounting, clerical and other services to carry out the Plan. The costs of these services and other administrative expenses shall be paid by St. Petersburg College.

Delegation of Duties

The Plan has other fiduciaries, advisors and service providers. The Plan Administrator may allocate fiduciary responsibility among the Plan's fiduciaries and may delegate fiduciary or other responsibilities to others. Any such allocation or delegation must be done in writing and kept with the records of the Plan.

Each fiduciary is solely responsible for its own improper acts or omissions. No fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became, or after it stopped being, a fiduciary.

Plan Fiduciaries

St. Petersburg College shall be a named fiduciary of the Plan. The Plan has other fiduciaries, advisors and service providers. The Plan Administrator may allocate fiduciary responsibility among the Plans' advisors and service providers and may delegate fiduciary or other responsibilities to others. Any such allocation or delegation must be done in writing and kept with the records of the Plan.

Certain benefits described in this booklet are provided pursuant to insured contracts issued to the Plan Administrator by various insurance companies. The insurers are the named fiduciaries with respect to claims administration for their respective benefits. The Plan Administrator retains all its other authority.

Each fiduciary is solely responsible for its own improper acts or omissions. Except to the extent required by law, no fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became, or after it stopped being, a fiduciary. However, a fiduciary may be liable for a breach of fiduciary responsibility of another Plan fiduciary, to the extent provided by law.

Liability of Administrative Personnel

Neither St. Petersburg College nor any of its officers, directors, agents, representatives, or Employees shall be liable for any loss due to an error or omission in administration of the Plan unless the loss is due to the willful misconduct of the party to be charged or is due to the failure of the party to exercise a fiduciary responsibility with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character with like aims.

Expenses

Except as otherwise provided in the Plan, all expenses and charges incurred in the administration and operation of the Plan, including fees and expenses which the Committee agrees to pay agents or professionals employed or retained pursuant hereto, shall be paid out of the assets of the Employer. No compensation shall be paid by the Plan to any member of the Committee or the administrator if employed by the Employer but said persons may be reimbursed for their reasonable expenses incurred in carrying out their duties, responsibilities and authority hereunder, and the compensation, or the properly allocable portion thereof, paid to other Eligible Employees who are involved in the administration and operation of the Plan and all other properly allowable expenses shall, to the extent not paid by the Employer, be treated as administrative expenses. No bond shall be required of the members of the Committee or the administrator, except as otherwise required by law.

Establishment of Pool

Prior to the commencement of the Plan Year, the Plan Administrator may, in its sole discretion, designate an aggregate dollar amount that it will make available for reimbursement of Eligible Expenses incurred for co-payments for inpatient hospitalization as described in Article V or for the treatment of Cancer or Dread Disease expenses as described in Article VI for the Plan Year. The amount made available shall be divided between Eligible Employees and their Dependents ("Active Pool") and Retired Employees and their Dependents ("Retiree Pool").

The amount made available in the Active Pool shall be based on a ratio, the numerator of which is the number of Active Employees and the denominator of which shall be the total

number of Active Employees and Retired Employees. Likewise, the amount made available in the Retiree Pool shall be based on a ratio, the numerator of which is the number of Retired Employees and the denominator of which shall be the total number of Active Employees and Retired Employees. Each pool shall be separately maintained and shall be unfunded.

Active Employees and their Dependents shall submit claims to the Active Pool; Retired Employees and their Dependents shall submit claims to the Retiree Pool. Amounts available from the Active Pool and the Retiree Pool shall be available for reimbursement of Eligible Expenses on a "first come, first served" basis. After a pool is depleted for a Plan Year, no further Medical Reimbursement or Cancer and Dread Disease Reimbursement Benefits shall be payable to covered persons for such Plan Year. Any amounts remaining in the pools shall be retained by the Employer. *Notwithstanding the preceding sentences, after the commencement of the Plan Year, the Plan Administrator may designate additional amounts to be made available for reimbursement of Eligible Expenses*

Funding Policy

The Plan Administrator shall determine the funding policy of the Plan, with the advice of such experts as the Plan Administrator deems appropriate. Some or all of the benefits under the Plan may be provided through insurance contracts. The Plan Administrator reserves the right to change the funding policy and/or insurance contracts at any time.

Claims Procedure: Medical Reimbursement and Cancer and Dread Disease Reimbursement Benefits

(a) Application for Claims. Any claim for Medical Reimbursement Benefits or Cancer and Dread Disease Reimbursement Benefits under the Plan shall be submitted to the Benefit Administration Manager. The Benefit Administration Manager shall be responsible for making an initial determination concerning the payment of such claim on behalf of the Plan Administrator.

(b) Limitations. Notwithstanding anything in the Plan to the contrary, no Medical Reimbursement Benefits or Cancer and Dread Disease Reimbursement Benefits shall be payable under the Plan to any individual who fails to submit a claim for benefits hereunder within 180 days after the date covered Expenses were incurred, provided that the Committee, in its sole discretion, may accept a claim after such time has

elapsed if extenuating circumstances prevented the individual from making a claim during such period but in no event more than 12 months from the date the covered expenses were incurred.

Each individual shall file with the Benefit Administration Manager such pertinent information concerning himself as the Benefit Administration Manager may specify, in such manner and form as the Benefit Administration Manager may specify or provide, and such person shall not have any rights or be entitled to any benefits or further benefits hereunder, as the case may be, unless such information is filed by him or on his behalf. Each individual claiming benefits under the Plan shall supply any additional information which the Benefit Administration Manager may request that Medical expenses were incurred or that the expense is covered under the Plan. If the Benefit Administrator Manager shall determine that a individual has not incurred a covered expense or that the benefit is not covered under the Plan, or if the individual shall fail to furnish such proof as is requested, no benefits or no further benefits hereunder, as the case may be, shall be payable to such individual.

(c) Notification of Decision. Notice of a decision with respect to a claim shall be furnished to the individual within 90 days following the receipt of the claim unless special circumstances require an extension of time for processing the claim. If there is a need for such an extension, the Benefit Administration Manager shall furnish written notice of the extension to the individual prior to the expiration of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of the initial 90-day period. The notice of extension shall indicate the special circumstances requiring the extension and the date by which the notice of decision with respect to the claim shall be furnished. Commencement of benefit payments shall constitute notice of approval of a claim to the extent of the amount of the approved benefit. If such claim shall be wholly or partially denied, such notice shall be in writing and worded in a manner calculated to be understood by the individual, and shall set forth: (a) the specific reason or reasons for the denial; (b) specific reference to pertinent provisions of the Plan on which the denial is based; (c) a description of any additional material or information necessary for the individual to perfect the claim and an explanation of why such material or information is necessary; and (d) an explanation of the Plan's claims review procedure. If the Benefit Administration Manager fails to notify the individual of the decision regarding his claim in accordance with this Article, the claim shall be deemed denied and the individual shall then be permitted to proceed with the claims review procedure.

(d) Claims Review Procedure. Within 60 days following receipt by the individual of notice of the claim denial, or within 60 days following the close of the 90-day period referred to in the section "Notification of Decision," if the Benefit Administration Manager fails to notify the individual of the decision during such time period, the individual may appeal denial of the claim to the Committee. The individual shall be given an opportunity to review pertinent documents and to submit issues and comments in writing. A request for review by the Committee shall be in writing and shall contain all additional information which the individual wishes the Committee to consider. Following such request for review, the Committee shall fully and fairly review the decision denying the claim. The Committee may hold a hearing or conduct an independent investigation regarding the merits of the claim denial. Within 60 days following receipt of the individual's request for review or within 120 days after such receipt where there are special circumstances requiring an extension of time for reviewing such claim, the Committee shall deliver the decision to the individual in writing. If the decision on review is not furnished within the prescribed time, the claim shall be deemed denied on review.

For all purposes under the Plan, such decision on claims where no review is requested and decisions on claims where review is requested shall be final, binding and conclusive on all interested parties.

Claims Procedure: Medical Program

With respect to any claim for benefits under the Medical Insurance Program, a written application for benefits shall be submitted to the appropriate insurer. The insurer shall be responsible for deciding such claim, for providing a full and fair review of the decision and for directing a Participant or Dependent's entitlement to benefits provided under the insurance contract.

Right of Recovery

Whenever benefits received have been a total amount at any time in excess of the amount of payment necessary, the Plan Administrator shall have the right to recover such payments to the extent of such excess from the Participant to whom such payments were made.

Notices

Any notice, application, instruction, designation or other form of communication required to be given or submitted by any Participant shall be in such form as is prescribed from time to time by the Committee, sent by inter-office mail, first class mail or delivered in person to the Committee of the Plan. Any notice, statement, report or other communication from the Employer, the Committee, the Benefit Administration Manager, or the administrator to any Participant, other Eligible Employee or beneficiary required or permitted by the Plan shall be deemed to have been duly delivered when given to such person or mailed by first class mail to such person at his address last appearing on the records of the Employer. Each person entitled to receive benefits under the Plan shall file in accordance herewith his complete mailing address and each change therein.

Agent for Service of Legal Process

The agent for the service of legal process under the Plan shall be the Committee or its designated representative.

Legal Actions

In any action or proceeding regarding the administration of the Plan, Employees or Retired Employees of St. Petersburg College or their beneficiaries, or any other persons having or claiming to have an interest in this Plan, shall not be necessary parties and shall not be entitled to any notice of process. Any final judgment which is not appealed or appealable shall be binding and conclusive on the parties hereto and all persons having or claiming to have any interest in this Plan. To the extent permitted by law, if a legal action is begun against St. Petersburg College, the Plan Administrator, or an organization providing Benefits under the Plan by or on behalf of any person and such action results adversely to such person, or if a legal action arises because of conflicting benefit claims, the cost to St. Petersburg College, the Plan Administrator, or such other organization of defending the action will be charged to the sums, if any, which were involved in the action or were payable to the Participant, beneficiary or other person concerned.

Alienation of Benefits

No amount payable at any time hereunder shall be subject in any manner to alienation by anticipation, sale, transfer, assignment, bankruptcy, pledge, attachment, charge or encumbrance of any kind, and any attempt to alienate, sell, transfer, assign, pledge, attach, charge or otherwise encumber any such amount, whether presently or hereafter payable, shall be void. The Plan shall not be liable for or subject to the debts or liabilities of any person entitled to any amount payable under the Plan, or any part thereof, or if by reason of his bankruptcy or other event happening at any such time such amount would not be enjoyed by him, then the Committee, in its sole discretion, may terminate his interest in any such amount and shall hold or apply it to or for the benefit of such person, his spouse, children or other dependents, or any of them, in such manner as the Committee may deem proper. In addition, the Plan may permit assignment of benefits to a child's custodial parent or legal guardian to the extent necessary to comply with a Qualified Medical Child Support Order.

Qualified Medical Child Support Orders

The Plan Administrator shall adhere to the terms of any medical child support order that satisfies the requirements of Sections 401(e) and 401(f) of the Child Support Performance and Incentive Act of 1998 (CSPIA). A medical child support order is any judgment, decree or order (including approval of a property settlement agreement) issued by a court of competent jurisdiction which (i) relates to the provision of child support with respect to the child of a Participant under a group Medical plan (including this Plan) or provides for Medical benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to such benefit under such group Medical plan, or (ii) enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13623 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group Medical plan, and which creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to receive benefits payable with respect to a Participant or beneficiary under a group Medical plan.

For purposes of this Section, an "alternate recipient" shall mean any child of a Participant who is recognized by a qualified medical child support order as having the right to enrollment under a group Medical plan with respect to such Participant.

In order to be qualified, a medical child support order must (1) clearly specify the name and last known mailing address of the Participant and the name and mailing address of each alternate recipient covered by the order, (2) contain a reasonable description of the type of coverage to

be provided under the group Medical plan to each such alternate recipient (or the manner in which such type of coverage is to be determined), (3) state the period to which such order applies, and (4) designate each plan to which such order applies.

Any such medical child support order shall not require the Plan to provide any type of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13623 of the Omnibus Budget Reconciliation Act of 1993).

The Plan Administrator shall promptly notify the Participant and each alternate recipient of the receipt of a medical child support order by the Plan and the Plan's procedures for determining the qualified status of medical child support orders. Within a reasonable period after receipt of a medical child support order, the Plan Administrator shall determine whether such order is a qualified medical child support order and shall notify the Participant and each alternate recipient of such determination. If the Participant or any affected alternate recipient disagrees with the determinations of the Plan Administrator, the disagreeing party shall be treated as a claimant and the claims procedures of the Plan shall be followed. The Plan Administrator may bring an action for a declaratory judgment in a court of competent jurisdiction to determine the proper recipient of the benefits to be paid by the Plan.

Alternate recipients of a qualified medical child support order shall be treated as a beneficiary under the Plan.

Payments under the Plan under a qualified medical child support order described in this section in reimbursement for expenses paid by the alternate recipient or the alternate recipient's custodial parent or legal guardian shall be made to the alternate recipient or the alternate recipient's custodial parent or legal guardian.

Right to Amend or Terminate

The Board shall have the right at any time to amend or modify the Plan, retroactively or otherwise, or to terminate or partially terminate the Plan, provided that no such amendment or termination shall in any manner impair the right of a Participant who is entitled to benefits under the Plan upon the adoption of such amendment to receive benefit payments provided for herein or under the Plan prior to such amendment. Participants will be notified in writing of any Plan amendments or Plan termination.

Filing of Information

Each Eligible Employee or other interested person shall file with the Committee such pertinent information concerning himself as the Committee may specify, including proof or continued proof of dependency or eligibility, and in such manner and form as the Committee may specify or provide, and such person shall not have rights or be entitled to any benefits or further benefits hereunder unless such information is filed by him or on his behalf.

Payment to Others than Participants

If the Committee shall find that any person to whom any benefits are payable under the Plan is unable to care for his affairs, then any payment due to him or his estate (unless a prior claim therefore has been made by a duly appointed legal representative) may be paid to the spouse, a child, a relative, an institution maintaining or having custody of such person, or any other person deemed by the Committee to be a proper recipient on behalf of such person otherwise entitled to payment, or the Committee may in its discretion hold such payment until a legal representative is appointed. Any such payment shall be a complete discharge of the liabilities of the Plan.

No Waiver or Estoppel

No term, condition or provision of the Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of the Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

Severability

If any provision of this Plan is held invalid or unenforceable, the invalidity or unenforceability will not affect any other provision, and this Plan will be construed and enforced as if the invalid or unenforceable provision had not been included.

Limitation on Actions

No action at law or in equity shall be instituted to recover under the Plan prior to the expiration of the completion of the claims and appeal process as described in "Claims Procedure: Medical Reimbursement and Cancer and Dread Disease Reimbursement Benefits". Nor shall any such action be instituted at any time unless instituted within three years after the date the expenses which are the subject of or are otherwise involved in such action are incurred or are alleged to have been incurred; provided that any limitation on actions regarding benefits shall be as provided in the Plan.

No Guarantee of Tax Consequences

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of an individual under the Plan shall be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment shall apply to or be available to any individual. It shall be the obligation of each Participant to determine whether such payment under the Plan is excludable from the Participant's gross income for federal or state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable.

No Vested Interest

Except for the right to receive any benefit payable under the Plan, no person has any right, title or interest in or to the assets of St. Petersburg College because of the Plan.

Clerical Error

Any mistake of fact or misstatement of fact shall be corrected when it becomes known and proper adjustment made by reason thereof.

Nondiscrimination

The Plan shall be administered in accordance with applicable federal and state laws prohibiting discrimination, including but not limited to, the Age Discrimination in Employment Act (ADEA), Older Workers Benefits Protection Act (OWBPA) and nondiscrimination requirements under the Internal Revenue Code. The Plan Administrator

reserves the right to modify the Plan and/or benefits provided in order to comply with applicable state and federal laws.

Additional Standards under the Social Security Act

Notwithstanding any other provision of the Plan to the contrary, in all instances the Plan shall be operated in accordance with the requirements of Section 1908 of the Social Security Act.

Construction

The Plan shall be construed according to the laws of the State of Florida, and all provisions hereof shall be administered according to the laws of said state.

Headings

All article and section headings herein have been inserted for convenience only and shall not affect the meaning of the language contained herein.

Gender and Number

The masculine gender shall be deemed to include the feminine and the singular shall include the plural unless otherwise clearly required by the context.

APPENDIX A

INSURANCE INFORMATION

Health and Dental Insurance Programs

Insurance Carrier	Florida Blue (800) 352-2583
Dental	MetLife (888) 309-5526

Vision Insurance Program

Insurance Carrier -	EyeMed Vision Care 4000 Luxottica Pl Mason OH 45040 (866) 939-3633
Third Party Administrator	Custom Benefit Services P.O. Box 4078 Ocala FL 34478-4078 (800) 809-8161