RETIREE HEALTH PLAN OF THE
MIAMI ASSOCIATION OF FIRE FIGHTERS HEALTH BENEFIT TRUST

SUMMARY PLAN DESCRIPTION

a. Name of Plan

This Plan is known as the "Retiree Health Plan of the Miami Association of Fire Fighters Health Benefit Trust" (Effective January 1, 2003, Amended and Restated Effective __________________, 2018). It is funded through the "Miami Association of Fire Fighters Health Benefit Trust"(Effective January 1, 2003, Amended and Restated Effective __________________, 2018). For a copy of the documents, please contact the Trust Office (part **e** hereof).

b. Name, Address and Telephone Number of Employee Organizations That Established Plan

The Plan was established by the Miami Association of Fire Fighters, Local 587; which is located at:

Miami Association of Fire Fighters, Local 587
2980 NW South River Drive
Miami, FL 33125-1146
Phone: (305) 633-3442

c. Identification Numbers

The Employer Tax Identification Number assigned to the Plan by the Internal Revenue Service is EIN 03-6100362.

The Plan number is 501.

d. Type of Plan

The Plan can be described as a welfare benefit plan providing post employment health insurance premium reimbursement benefits and other qualified healthcare expenditures.

e. Type of Administration/Trust Office

The Plan is administered by the Board of Trustees of the Miami Association of Fire Fighters Health Benefit Trust. The Trustees may retain a contract administrator to assist in Plan administration. You may contact the Trust Office, at 2980 NW South River Drive, Miami FL 33125-3442, Phone: (305) 633-3442, with questions.

f. **Plan Administrator**

The Plan Administrator (fiduciary) is the Board of Trustees of the Miami Association of Fire Fighters Health Benefit Trust, whose members are listed in part **h** hereof. They may also be contacted in care of the Trust Office (part **e**).

The third party administrator (TPA) is Diversified Administration. You may contact the third party administrator, at 6161 Washington Street, Hollywood, FL 33023, Phone: (954) 983-9970, with questions.

g. **Name and Address for Agent for Service of Process**

Each member of the Board of Trustees is an agent for purposes of accepting service of legal process on behalf of the Plan. Service of legal process may be made upon a Plan Trustee at the address set forth in part **h** hereof, or upon the Trust Office at the address in part **e** above.

h. **The Names and Addresses of the Trustees**

Thomas Gabriel
Miami Association of Fire Fighters, Local 587
2980 NW South River Drive
Miami, FL 33125-1146

Jorge Megias
Miami Association of Fire Fighters, Local 587
2980 NW South River Drive
Miami, FL 33125-1146

Patrick Murdock
Miami Association of Fire Fighters, Local 587
2980 NW South River Drive
Miami, FL 33125-1146

Robert Hardy
Miami Association of Fire Fighters, Local 587
2980 NW South River Drive
Miami, FL 33125-1146

Nicholas Stein
Miami Association of Fire Fighters, Local 587
2980 NW South River Drive
Miami, FL 33125-1146

i. **Description of Bargaining Agreement**

The Plan is maintained pursuant to an Agreement between the City of Miami and the Miami Association of Fire Fighters, Local 587, effective October 1, 2001, to September 30, 2004, and applicable successor agreements. Beneficiaries of the Plan (i.e., employees, eligible retirees, surviving spouses, including, but not limited to, same-sex spouses and domestic partners, qualified relatives, and dependents), as defined in the Plan and Trust documents, may obtain copies of the Agreement upon written request to the Plan Administrator. Further, the Agreement is available for examination by Beneficiaries at the Plan Administrator's office. The Trustees may impose a reasonable charge to cover the cost of providing copies of the Agreement. Beneficiaries may wish to inquire as to the amount of the charges before requesting copies.

j. **Participation, Eligibility and Benefits**

1. **Participation**. Eligibility in the Plan is generally open to all employees who are members of a bargaining unit that has signed a Collective Bargaining Agreement with a Participating Employer which requires contributions to this Trust and for whom the required contributions are made to the Trust. See Plan Sections 1.11 and 1.12 for details.

   Eligibility Rules. Such employees become entitled to benefits of the Plan, upon termination of employment with the Participating Employer, provided the employees have completed ten (10) years of service or retired by reason of disability under any pension plan of a Participating Employer. See Plan Sections 1.18 and 5.2.

   Employees who terminate from employment with less than 10 years may use the benefits as described herein to the limits of the employee's self contribution. However, no City contribution shall be allocated to their account for use for benefits.

   Benefits. Eligible Retirees are entitled to reimbursement toward the payment of Qualified Expenses not to exceed the amount in the Employee Account of the Retiree or former Employee. There are also benefits for eligible Surviving Spouses, Dependents, and Qualified Relatives as set forth in Plan Section 5.3 – 5.6. Qualified Expenses generally include premiums of health, dental, vision, and other medical insurance; and miscellaneous medical expenses that are deductible under Section 213(d) of the Internal Revenue Code. See Plan Section 1.22.

2. **Procedures Governing Qualified Medical Child Support Order Determinations (QMCSO).** Beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator (noted in part **e**).

3. **Description of Cost Sharing Provisions.** The Plan reimburses toward the cost of

Qualified Expenses, but may not cover the entire expense amount, depending on the Employee Account balance. Plan beneficiaries will be responsible for the balance of any Qualified Expenses they pay in excess of the Plan's benefit.

k. Circumstances Which May Result in Ineligibility or Denial of Benefits or Amendment or Termination of the Plan

Circumstances which may result in disqualification, ineligibility, denial or the loss of benefits include failure to make required contributions, failure to properly submit expense receipts, failure to meet the eligibility requirements, death, or termination of the Plan.

1. An Eligible Retiree's benefit coverage under this Plan shall terminate on the first to occur of the following: (a) the date the Retiree's Account Balance reaches zero; or (b) the date the Plan is terminated (subject to #4 below). Claims for qualified expenses, which are properly and timely submitted after death, will be paid until the balance in the Employee Account reaches zero.

2. Benefit coverage for a Surviving Spouse, Dependent, or Qualified Relative shall terminate on the first to occur of the following: (a) the date the Retiree's Account Balance reaches zero; (b) the date a Dependent or Qualified Relative would have lost dependent status had the Eligible Retiree lived; or (c) the date the Plan is terminated.

3. The Board of Trustees reserves the right to amend, modify or terminate this Plan at any time, as to current and/or future beneficiaries.

4. In the event of the termination of the Plan, assets of the Plan which remain after expenses associated with such termination, will be allocated among, and distributed to, the Beneficiaries in accord with Section 501(c)(9) of the Internal Revenue Code and related regulations. Balances in Employee Accounts will be distributed in the form of reimbursement benefits first to the Retiree/Beneficiary related to the Account; and then to other Beneficiaries of the Trust.

l. Source of Contributions

Contributions to the Plan are made by the City of Miami based on an Agreement between the City and the Miami Association of Fire Fighters, Local 587. There are also employee contributions from sick leave balances at the time of termination of employment.

m. Methods Used for Accumulation of Assets

Contributions are received by and held in trust by the Trust. The Trust may hire a professional investment manager, utilizing investment policies and methods consistent with objectives of this Plan to invest and manage the fund assets..

n. End of Plan Year

The Plan year runs from January 1 to December 31.

o. Procedures to be Followed in Presenting Claims for Benefits and Appeal Procedures for Denied Claims

The Plan's claim and appeal procedures will be furnished automatically, without charge, as a separate document. The claim procedures are also contained in Section 5.8 of the Plan and the appeal procedures are contained in Sections 6.1 – 6.3 of the Plan.

Benefit Claim Procedure

To make a claim for Plan benefits, a Claimant must present proof of payment of a Qualified Expense, on a form approved by the Trustees, to the Third Party Administrator (TPA) at:

Diversified Administration, Inc.
6161 Washington Street Hollywood, Fl 33023
Phone: (954) 983-9970 Fax: (954) 983-9695
E-mail: claims@div125.com

Prior to issuing payment, the TPA shall review such proof and determine whether to grant or deny coverage under the Plan.

All claims and appeals must be submitted by an Eligible Retiree. Upon the Eligible Retiree's death, the Eligible Retiree's Surviving Spouse must submit all claims and appeals. If there is no Surviving Spouse, then the Eligible Retiree's Dependents may submit claims and appeals.

If the TPA grants coverage, payment will be made to the Claimant. If the TPA denies coverage, the Claimant may appeal the denial of coverage or any other adverse benefit determination of the TPA as described under Appeal Procedures below.

Proof shall include, but not be limited to, canceled checks drawn to the name of the provider, or receipt for payment from the provider, subject to verification as determined by the TPA in their sole discretion.

Claims for Plan benefits must be submitted no later than 180 days from the date on which the Claimant made the payment of Qualified Expenses to the insurance provider. This 180-day limit may be waived by the Trustees upon good cause shown by the Claimant.

Subject to the below, unless specifically provided by law, the TPA shall not make any payments on behalf of or distributions to any person entitled to any benefits except to a Claimant personally, or pursuant to a Qualified Medical Child Support Order under federal law.

If a Claimant is deemed to be incompetent by a lawful judicial or quasi-judicial forum, or reasonably deemed to be incompetent by the Trustees, then any payment due may be paid to such person and in such manner as the Trustees, in their sole discretion, considered to be in the best interest of the Claimant (unless the judicial forum has appointed a party as the Claimant's representative, in which case the TPA will make payment to that party). The Trustees shall not be under any duty to oversee the application of funds so paid, provided due care was exercised in the selection of the person to whom funds were paid, and the receipt of the person to whom funds were paid shall be full quittance to the Trustees. The Trustees shall not be liable to any person for a determination made in good faith that a Claimant is incompetent.

CLAIM APPEAL PROCEDURES

Claimant's Duty to Notify Trustees of Claim. The Claimant is required to notify the TPA of his or her claim for benefits before he or she is entitled to either receive benefits under the Plan, or appeal the TPA decision denying a request for benefits as described under Benefit Claim Procedure.

Acceptance or Denial of Claim by Trustees.

Standard Claim Decision - Timing. The TPA shall consider each claim for Plan benefits and determine whether to grant or deny coverage under the Plan. Subject to the extension of time provisions below, the TPA shall send written notification of its decision to the Claimant not later than thirty (30) days after receipt of the Claimant's claim. If coverage is granted, the Claimant shall receive payment as described under Benefit Claim Procedure. If the claim is denied, the Claimant has the right to appeal the claim, as described under Appeal Procedures below.

The denial notification shall include the following information:

(1) The specific reason(s) for such denial;

(2) Specific reference to the Plan provisions upon which the denial is based;

(3) 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 Claimant's claim for benefits; and

(4) An explanation of the Plan's "Appeal Procedures," if any, with respect to the denial of benefits and a statement of the Claimant's right to bring an action in court, after exhausting the Plan's appeal procedures.

Extension of Time - Special Circumstances. If the Trustees determine that special

circumstances require an extension of time for processing the claim, written notice of the extension shall be furnished to the Claimant prior to the termination of the initial thirty (30) day period. The extension notice shall indicate the special circumstances requiring the extension of time and the date by which the Trustees expect to render a benefit determination. In no event shall such extension exceed a period of fifteen (15) days from the end of the initial period (45 days total).

Extension of Time - Failure to Submit Information. The period of time for the Trustees to make a benefit determination may be extended if the Claimant fails to submit all necessary information to allow the Trustees to decide the claim. In such case, the period for deciding the claim is tolled from the date on which the request for additional information is sent to the Claimant until the date the Claimant provides to the Trust Office the requested information. The Claimant shall be allowed at least forty-five (45) days from receipt of the request for additional information within which to provide the information.

Appeal Procedures. The Trustees, Claimants and any person who claims to be entitled to benefits under the Plan shall follow the below appeal provisions.

Sole Procedures. The procedures specified in this Section shall be the sole and exclusive procedures available to a person dissatisfied with an eligibility determination or benefit award, or who is otherwise adversely affected by any action of the Trustees.

Request for Hearing. Any person whose claim has been denied may appeal to the Trustees to conduct a hearing in the matter, provided that he or she requests the hearing in writing within one hundred eighty one (181) calendar days after receipt of notification of the denial of benefits or other adverse determination. The letter requesting a hearing should also indicate the reasons why the Claimant believes that the grounds for denial of benefits are inapplicable. The Claimant may request and examine documents pertinent to the denial and may submit written comments, documents, records and other information relating to the claim for benefits to the Trustees. The Claimant shall also be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits.

Hearing Procedure. The Trustees shall conduct a hearing at the next regularly scheduled meeting of the Board of Trustees, unless the request for review is received by the Trust Office within thirty (30) days preceding the date of such meeting. In such case, the hearing will be conducted no later than the date of the second meeting following the Trust Office's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the Plan's procedures provide for a hearing) require a further extension of the time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the Plan's receipt of request for review. If such an extension of time

for review is required because of special circumstances, the Trustees shall notify the claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Trustees will review all comments, documents, records and other information submitted by the Claimant related to the claim, regardless of whether such information was submitted or considered in the initial benefit determination. The Claimant shall be entitled to present his or her position and any evidence in support thereof at the hearing. The Claimant may be represented by an attorney or any other representative of his or her choosing at the Claimant's expense.

Decision After Appeal Hearing. No later than fifteen (15) days after the hearing is held the Trustees shall notify the claimant of the decision either by issuing a written decision, affirming, modifying or setting aside the former decision. Any notification of a denial of benefits shall include the following information:

(1) The specific reason(s) for such denial;

(2) Specific reference to the Plan provisions upon which the denial is based;

(3) 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 Claimant's claim for benefits; and

(4) An explanation of the Claimant's right to bring an action in court.

Right to Court Review. Upon exhaustion of the above procedures, the Claimant who is dissatisfied with an eligibility determination or benefit award, or who is otherwise adversely affected by any action of the Trustees, may then bring an action in court.

p. Statement of Legal Rights

1. **Rights of Plan Participants.** Beneficiaries of the Miami Association of Fire Fighters Health Benefit Trust are entitled to certain rights and protection:

(a) Examine without charge at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing this Plan, including collective bargaining agreements, insurance, and contracts.

(b) Obtain upon written request to the Plan Administrator, copies of documents governing the operation of this Plan, including, insurance contracts and collective bargaining agreements. The Plan Administrator may charge a reasonable fee for the copies.

(c) Receive the Plan's financial report.

2. **Prudent Actions by Plan Fiduciaries.** The persons who operate your Plan and Trust are called "fiduciaries" in the law. Fiduciaries must act solely in the interest of the Plan Beneficiaries and they must exercise reasonable prudence in the performance of their Plan and Trust duties.

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

   There are steps that can be taken to enforce the above rights. For instance, if you request a copy of Plan documents or the latest report from the Plan and do not receive them within thirty (30) days, you may file suit in court. In such a case, the court may require the Plan Administrator to provide the materials. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state court after exhausting the Plan's administrative procedures. 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 the court finds your claim to be frivolous.

4. **Assistance with Your Questions.** If you have any questions about this Plan, you should contact the Plan Administrator (see part **e** above).

5. **Privacy Rights.** The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) will require special precautions of health benefit plans to protect the privacy of "protected health information," effective April 14, 2004. In the course of providing benefits to you under the Plan, the Trust Office may acquire protected health information. Accordingly, we are developing procedures to restrict access to protected health information to persons who need to know it in order to process, complete, or administer the Plan benefits. If you would like more details about your privacy rights, please contact the Trust Office (see part **e** above).

NOTE: This Summary has been designed to provide you with key information about the Miami Association of Fire Fighters Health Benefit Trust but it does not provide all the details and limitations of the Plan. Exact specifications are provided in the "Retiree Health Plan of the Miami Association of Fire Fighters Health Benefit Trust (Amended and Restated, Effective ___________________, 2018)," which will prevail in case of conflict with this Summary.