PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

FOR

CITY/COUNTY DENTAL, WELLNESS, PARTIAL SELF FUNDED HEALTHCARE PLAN, AND WRAP PLANS

CITY OF BURLINGTON, IOWA

DES MOINES COUNTY, IOWA
&
RELATED GOVERNMENTAL AGENCIES

EFFECTIVE JULY 1, 1983
AMENDED AND REVISED JULY 1, 2012

ADMINISTERED BY

EMPLOYEE BENEFIT SYSTEMS
214 NORTH MAIN STREET, P.O. BOX 1053
BURLINGTON, IA 52601
319-752-3200   800-373-1327   FAX 319-753-6114
www.ebs-tpa.com

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GENERAL PLAN INFORMATION

Type of Administration

This document describes the City/County Health Care Plan for Partially Self-Funded Medical Coverage. The Medical coverage, including prescription drug coverage, is provided through a fully insured plan utilizing Partial Self-Funding. The governance of claims approved is administered by Wellmark Blue Cross Blue Shield of Iowa.

Plan Name: City/County Health Care Plan for Partially Self-Funded Medical

Wellmark Blue Cross Blue Shield Plan Number: 36264

Tax I.D. Number: 42-199349

Plan Effective Date: July 1, 2003

Plan Year Begins: July 1

Plan Year Ends: June 30

Type of Administration

This document also describes the City/County Self Funded Wrap, Dental, and Wellness Coverages.

Plan Name: City/County Health Care Plan Self Funded Wrap, Dental, and Wellness Plans

Tax I.D. Number: 42-199349

Plan Effective Date: July 1, 1983

Plan Year Begins: July 1

Plan Year Ends: June 30

CLAIM INSTRUCTIONS

ALL CLAIMS MUST BE FILED WITHIN 365 DAYS AFTER THE END OF THE CALENDAR YEAR IN WHICH THE EXPENSE IS INCURRED

HOW TO FILE A DENTAL OR WRAP CLAIM

You or your Doctor may file claims directly with Employee Benefit Systems (EBS), using either their standard forms, or itemized bills with a diagnosis, procedure code and your ID number. Please attach your primary Explanation of Benefit (EOB) when filing for wrap benefits.

BENEFITS WILL BE PAID DIRECTLY TO THE PHYSICIAN OR OTHER HEALTH CARE SERVICE PROVIDER - UNLESS THE BILL IS MARKED PAID WHEN THE CLAIM IS RECEIVED. IF YOU ARE FILING A BILL WHICH YOU HAVE ALREADY PAID, PLEASE INDICATE THIS FACT CLEARLY ON THE CLAIM.

You will receive copies of all payments along with an explanation of how the benefits were calculated.

Claims will normally be approved or denied promptly by the Claims Administrator. In any case, they will be approved or denied within 30 days after they are received although an extra 15 days may sometimes be necessary. You will be given notice of any extension and the notice will tell you why the extension was necessary. In the unlikely event you do not receive a response within 45 days after your claim is filed, please call EBS. If your claim is denied or reduced, you may appeal. The appeal procedure is described in the back of this book.

CLAIMS ADMINISTRATOR:

EMPLOYEE BENEFIT SYSTEMS
214 NORTH MAIN STREET, P.O. BOX 1053
BURLINGTON, IOWA 52601
(319) 752-3200, 1-800-373-1327 FAX (319) 753-6114
www.ebs-tpa.com

YOU MAY CALL OR VISIT THE EBS OFFICE AT ANY TIME - BUSINESS HOURS ARE:

8:00 AM TO 5:00 PM, MONDAY THROUGH FRIDAY

TO ALL ELIGIBLE EMPLOYEES:

Your group benefit program is designed to provide adequate protection and to meet the insurance needs of the members and their dependents. The purpose of this Plan is to help protect you and your family from financial problems caused by injury or illness.

This Plan is as comprehensive as possible, consistent with sound financial policy. To help you understand this coverage and how it will best service you, the following pages of this booklet describe some of the benefits available to you.

Participating Agencies

City of Burlington, Iowa

County of Des Moines, Iowa

Burlington Municipal Waterworks

Southeast Iowa Regional Airport Authority

Des Moines County Regional Solid Waste Commission

Two Rivers Levee and Drainage District Association

City of Danville, Iowa

ARTICLE I

USING THE PLAN BOOKLET

Introduction: This is not just a general summary of your Plan, but the actual plan document written so that it can be used by you, the Employer and the Claim Administrator in administering the Plan.

Eligibility and Special Enrollment: Your enrollment provisions are described in Article II.

Partial Self Funded Health: Your Benefits are described in Article III

Wrap Plan: Your Benefits are described in Article IV.

Dental: Your Benefits are described in Article V.

Wellness: Your Benefits are described in Article VI.

Definitions: In Article VII, you may reference many definitions that will assist you in clarifying the details of benefits.

Term and Termination: Article VIII provides the conditions for termination of coverage from this Plan, including the provisions for continuation of benefits under law.

COBRA: Article IX provides for continuation of benefits under the plan in the event of separation of service.

General Provisions: Article X sets forth general provisions important to the administration of the Plan, including the government required information.

Claim Review and Appeal Procedure: Article XI sets forth procedures for appealing any decisions of the Claims Administrator. You may appeal to the Claims Administrator and/or to the Board of Directors of the Health Care Plan.

HIPAA: In Article XII we have explained HIPAA use and disclosure of protected health information.

ARTICLE II

ELIGIBILITY and SPECIAL ENROLLMENT

1. Commencement of Coverage of Eligible Employees and their Dependents under this Plan will begin at 12:01 a.m.:

(a) The date you become eligible for employee insurance, which is the first day of the month following date of hire.

(b) In the case of a dependent, the date as of which that person is first a dependent of an eligible employee. Dependents are not automatically covered, their coverage is elective.

(c) Employee means an employee of a participating Employer who has met the requirement for participation in the Plan as set out by their Employer.

2. Enrollment. To be covered you must elect to participate in the Plan by completing the required enrollment forms furnished by the Employer within 30 days of your first day of employment. This requirement applies whether you are an eligible employee or a dependent.

3. Special Enrollment. Certain contract changes are allowed if the application is received within 30 days of the event. Failure to notify your employer within 30 days could result in a loss of benefits.

a) Marriage
b) Addition of family member
c) Divorce, annulment, or legal separation
d) Death of spouse or dependent
e) Eligibility for Medicare
f) Exhaustion of COBRA
g) Member, spouse, or dependent loses eligibility for creditable coverage or his or her employer sponsor ceases contribution to creditable coverage
h) Spouse losses coverage through his or her employer
i) Military enlistment of yourself or dependent
j) Dependent who is not a full-time student or permanently disabled reaches age 26 (age 25 for Dental and Wrap Plan benefits – additional eligibility requirements may apply)
k) Completion of dependent’s full time schooling if the dependent is age 26 or older (age 25 for Dental and Wrap Plan benefits – additional eligibility requirements may apply)
l) Change in hours from part time to full time or full time to part time.

Certain contract changes are allowed if the application is received within 60 days of the following events. Failure to notify your employer within 60 days could result in a loss of benefits

a) Birth, adoption, or placement for adoption of child;
b) Drop coverage or add coverage if you, your spouse or your dependent ceases to be eligible for Medicaid or SCHIP coverage or becomes newly eligible for premium assistance under Medicaid or SCHIP. For purposes of these events only, the new election must be made within sixty (60) days of the termination of coverage or eligibility for premium assistance.

Duplicate Coverage: If both husband and wife are employed by the same or different employers covered by this Plan, each may carry single coverage in lieu of family coverage. However, if either have eligible Dependents, only one may carry family coverage on the entire family unit. A person may not be covered as both an Employee and as a Dependent.

ARTICLE III

PARTIAL SELF FUNDED HEALTH

Benefits offered through the City/County Health Care Plan, for employee health coverage are Partially Self-Funded (PSF). A fully insured health plan through Wellmark Blue Cross & Blue Shield of Iowa is purchased with high Deductible and Out-of-Pocket benefit limits. The PSF portion of the Plan processes any claims going to Deductible and Out-of-Pocket down to the Deductible and Out-of-Pocket limits established for City/County employees.

The Wellmark fully insured summary plan description (SPD) governs the plan coverage features, limits and exclusions of Medical and Prescription Drug Coverage. Under the Partially Self-Funded contract, annual Deductible maximums and annual Out-of-Pocket maximums are funded and paid from the PSF account. Prescription drug claims, Doctor's office co-pays, Deductible amounts in excess of the PSF and Out of Pocket maximums in excess of the PSF are covered under the Wellmark fully insured portion of the contract.

PARTIALLY SELF-FUNDED (PSF) HEALTH COVERAGE

PLAN FEATURES

Plan A

Calendar Year Deductible per Person	$ 100
Calendar Year Deductible per Family	$ 200
Out-of-Pocket Calendar Year Maximums:	
Per Person	$ 650
Per Family	$1,300

These amounts include Deductibles

Plan B

Calendar Year Deductible per Person	$ 250
Calendar Year Deductible per Family	$ 500
Out-of-Pocket Calendar Year Maximums:	
Per Person	$1,000
Per Family	$2,000

These amounts include Deductibles

Plan C

Calendar Year Deductible per Person	$ 500
Calendar Year Deductible per Family	$ 1,000
Out-of-Pocket Calendar Year Maximums:	
Per Person	$1,500
Per Family	$3,000

These amounts include Deductibles

Plan D

Calendar Year Deductible per Person	$1,000
Calendar Year Deductible per Family	$2,000
Out-of-Pocket Calendar Year Maximums:	
Per Person	$2,000
Per Family	$4,000

These amounts include Deductibles

Plan E

Calendar Year Deductible per Person	$2,000
Calendar Year Deductible per Family	$4,000
Out-of-Pocket Calendar Year Maximums:	
Per Person	$4,000
Per Family	$8,000

These amounts include Deductibles

All Plans

Co-Insurance (in network)	90%
Co-Insurance (out of network)	80%
RX CoPay	$5/$20/$35
Specialty Drug Copay	$85

RX Deductible (Waived for Generic) $100/$200

City of Burlington
SEIA Regional Airport Authority
City of Danville
Des Moines County Regional Solid Waste Commission
Drainage District #7

Office Visit CoPay (in network) $20

City of Burlington
SEIA Regional Airport Authority
City of Danville
Des Moines County Regional Solid Waste Commission
Drainage District #7
Burlington Municipal Waterworks

Office Visit CoPay (in network) $15

County of Des Moines
Two Rivers Levee
Drainage District #4

ARTICLE IV

WRAP PLAN

This Plan is a limited supplemental benefit Plan available only to Employees who have other group coverage. This coverage will always be considered as a SECONDARY supplemental Plan of benefits. The maximum yearly benefit under this Plan is $1,000 per member, per calendar year. This benefit is intended to cover all or part of another group's medical plan Deductible and Out-Of-Pocket payments, and Physician Office Visit Co-payments. It does not cover dental, vision, or prescription plan co-payments. The Wrap Plan does not cover charges denied by your primary plan. Benefits paid through the Wrap Plan are based on the Primary Insurance's Customary and Reasonable Charges, so that the Primary Insurance and Wrap Plan pay no more than 100% of the Primary Insurance's billed and Customary Reasonable Charges. You cannot wrap any other City/County Plan. The Wrap around Plan is not available as a secondary coverage to Medicaid.

ARTICLE V

DENTAL PLAN BENEFITS

When medically necessary, the Plan will pay for Dental Services provided to a Member by a Physician, limited to:

Anesthesia – you are covered for anesthesia, as well as hospital or ambulatory surgical facility charges, related to the provision of dental care, if the member:

- Is a child under 14, or
- Has a chronic disability or medical condition that requires inpatient treatment or general anesthesia for dental care.

Correction of Bone Abnormalities of the jaw that are demonstrable at birth.

Correction of a Lesion (an abnormal change in the mouth due to injury or disease).

Dental Treatment for Accidental Injury must be initiated within 72 hours of injury. If you receive initial treatment within 72 hours, follow-up care is covered for up to 30 days.

Injuries associated with or resulting from the act of chewing are never covered.

Manipulation of a jaw dislocation.

Reduction of Facial Bone Fractures.

Surgical Removal of Impacted Teeth as an inpatient or in the outpatient part of a facility only when you have a medical condition (such as hemophilia) that requires hospitalization.

Treatment of Temporomandibular Joint Disorders (TMJ) – however, you are not covered for physical therapy, manipulations, dental extractions, or orthodontic treatment for TMJ.

Plan #	Preventative Dental Services % Paid	Basic Services % Paid	Major Services % Paid After Deductible	Calendar Year Maximum	TMJ Services % Paid After Deductible	Orthodontic Services % Paid After Deductible	Orthodontic Lifetime Maximum
1	*100%/80%	*100%/80%	50%	$1,500	50%	50%	$1,500
2	*100%/80%	*100%/80%	50%	$1,500	50%	n/a	n/a
3	*100%/80%	80%	0%	$500	n/a	n/a	n/a

*Benefits are paid at 80% of CR the first calendar year a member is in the Plan and at 100% of CR the following years provided the Member has visited the dentist once in the previous calendar year and has completed the recommended dental work.

The Plan will pay the Customary and Reasonable (CR) fees of licensed dentists up to the maximum benefits shown in the table above per covered Member per calendar year. The Dental Plans have an "Incentive Mechanism" process which allows payment of benefits at 100% of CR unless the Member did not visit a dentist during the previous calendar year. In case the Member did not visit a dentist in the previous calendar year, benefits are payable at 80% of CR.

Benefits are paid at 80% of CR the first calendar year a member is in the Plan for:

- Routine oral exams, cleaning and polishing, and bitewing x-rays twice in a calendar year;
- Fluoride treatment up to age 19 twice in a calendar year;
- Full mouth x-rays once every two calendar years;
- Emergency exams and treatment to relieve pain, including prescriptions;
- Endodontics, including root canal therapy, pulp capping and pulpotomy;
- Amalgam and resin restorations;
- Denture repair and relining and recementing of inlays, onlays and crowns;
- Extractions, dental tests, oral surgery;
- Space maintainers, periodontal (gum) treatment and apicoectomy; and
- Sealants up to age 17.

Benefits Payable at 50 % of CR after a $25 deductible per calendar year per person include:

- Gold foil restorations, gold inlays and onlays, crowns and crown build-ups and implants;
- Dentures, full or partial; bridges, fixed or removable;
- Orthodontics: No payments will be made for orthodontic services rendered after the Member's 19th birthday; and
- Treatment of disturbances of the temporomandibular joint (TMJ) is limited to a lifetime maximum of $1,500, provided that treatment begins before the Member's 19th birthday.

Denture and Bridge Replacement: The replacement of existing bridges and dentures is covered when medically necessary not more than once in a five (5) year period.

Pre-Treatment Estimate: If your dentist feels that your dental work will cost more than $200.00, you should submit a pre-treatment plan to EBS. EBS will analyze the Treatment Plan and return an estimate of covered charges to you and to your dentist. Your dentist should review this estimate with you before treatment begins. No pre-treatment estimate is needed for emergency treatment.

This Pre-Treatment estimate is not a Plan requirement, but is offered as a valuable service to let you know how much your plan will cover before work actually begins. Regular claim forms can be used to request a pre-treatment estimate.

Deductible: Dental Plans 1 and 2 have a $25 per calendar year deductible per person. However, the deductible is not applicable for ANY OF THE PLANS FOR PREVENTIVE OR BASIC SERVICES. Since Plan 3 covers only preventive and basic services, that plan does not have a deductible.

Preventive Services means twice yearly routine exams and cleanings, sealants applied prior to a Member's 17th birthday, and fluoride treatments to age 19.

Basic Services means regular cavity fillings, oral surgery, periodontics and root canal treatment.

Major Services means crowns, bridges, dentures, implants, and appliances. Treatment of disturbances of the temporomandibular joint (TMJ) is subject to a $1,500 lifetime maximum for Plans that cover these Services, provided the treatment begins before the Member's 19th birthday.

Orthodontics means treatment necessary for the proper alignment of teeth prior to the Member's 19th birthday to a maximum of $1,500 Lifetime Benefit.

Dental Plan Exclusions: In addition to the general Plan Exclusions, the Dental Plan will not pay for:

1. Purely cosmetic work;
2. Charges for treatment incurred prior to the date coverage begins, or after the date coverage terminates;
3. Anesthesia or its administration, except for oral surgery;
4. Expenses for the replacement of lost, stolen or damaged appliances or prosthetic devices;
5. Benefits for illness or injury arising out of or in the course of employment, or for service provided by a governmental agency;
6. Any part of a charge for treatment or service that exceeds the CR as determined by EBS using proprietary dental claim data;
7. Instructions for plaque control, oral hygiene or diet;
8. Treatment or service to alter vertical dimensions or to restore occlusions;
9. Expenses for any experimental or investigational dental care;
10. Expenses for correction of any amount in excess of $1,500.00 per lifetime for treatment of disturbances of the TMJ, provided that such treatment begins before the Member's 19th birthday.

Enrollment in Dental Benefits is restricted to a minimum of two years, unless there is a family status change. If enrollment is dropped after a two year cycle,

that member shall not be allowed to again select any dental benefits for a period of two years.

ARTICLE VI

WELLNESS & PREVENTION

The City of Burlington/Des Moines County and participating agency employees, early retirees and members who are covered under COBRA are eligible for a $150 allocation towards the health care plan Wellness Program. This allocation can be used for wellness options received in Des Moines county and its adjoining counties. There are many options the Wellness Program has to offer for employees to choose from. A list of the options with a brief description is listed below.

Administration of the plan is done by Employee Benefit Systems (EBS). Billings should be sent directly to EBS for processing. They will pay the providers directly, the employee out of pocket expense up to the $150 allocation, unless you have paid and notify them of that on the billing.

PHYSICALS & SCREENS All physicals and screens to evaluate your general health, lifestyle, and identifies your current risk status for coronary heart disease, cancer, and other lifestyle related concerns. This includes Lifeline screening and Great River Health Fair screening. The program will reimburse the employee out of pocket expense only, up to the $150 allocation.

HEALTH FITNESS PROGRAM

A health fitness program helps you to maintain a healthy lifestyle through exercise and education. As a participant in a health fitness program, you will have a fitness evaluation to assist in personalizing your fitness program. The initial total assessment should include:

-body composition
-cardiovascular assessment
-equipment orientation
-exercise prescription
-flexibility assessment
-program set-up

PERSONAL TRAINING

One-on-One training sessions with a certified exercise specialist.

STRESS MANAGEMENT

Stress affects everyone. It’s the body’s way of coping with emotional and physical changes. Stress is a necessary part of our survival response. In today’s society, however, stress-related problems have become epidemic, causing a majority of our health problems. There is no question that stress can be either a motivator or a hindrance to our lives. This program is designed to help participants manage their stress successfully.

SMOKELESS – GRMC Center for Rehab

This stop smoking program is a positive approach to breaking the smoking habit. The system uses stress management, positive rewards and reinforcements, attitudinal transformation, food management, education, motivational tools and patented negative smoking techniques that will have you off cigarettes in 5 days. Best of all, Smokeless curbs withdrawal discomfort and irritability while it controls your weight.

SMOKING CESSATION MEDICATIONS

Patches, oral medications, gum.

AQUATIC AEROBICS

A pool is a wonderful treatment for individuals suffering from arthritis, poor flexibility or strength, and obesity. Program participants are led by trained personnel through a series of specially designed exercises. With the aid of the waters buoyancy and resistance, it can help improve joint flexibility, muscle strength, and physical endurance.

Specialized programs are:

Arthritis
Back injury or pain
Weight loss & toning
Physically challenged children
Stroke & head injury
Upper body focus
Lower body focus

YOGA

Yoga develops strength, stamina, flexibility, coordination and balance. Breath awareness and relaxation techniques are integrated with individualized body postures while your mind-body connection is enhanced. Get to know your body. Classes must be with a certified instructor.

CARDIAC REHABILITATION PHASE III

This program is offered to persons with a history of heart attacks or bypass surgery or with risk factors for heart or vascular disease. The supervised exercise sessions promote strength and endurance and increase cardiac conditioning.

FITNESS CENTERS

You can use all or any part of your $150 allocation to apply towards an “individual” or “family” fitness center membership or class at any approved public fitness center.

PUBLIC SWIMMING POOL PASSES

You can use all or any part of your $150 allocation to apply towards the cost of an annual swimming pool pass at any Public Swimming Pool or lessons with a certified instructor at an approved pool.

WEIGHT WATCHERS OR STRUCTURED WEIGHT REDUCTION PROGRAMS

Structured Weight Reduction Programs must have a licensed counselor on staff.. As an example, Weight Watchers diet is on a point system based on calories, fat, and fiber grams. Call 1-800-651-6000 for more information and to get the group name and Weight Watchers location nearest to you. Food is <u>not</u> considered an eligible expense.

PUBLIC GOLF COURSES

Season passes at public golf courses. Golf Cart rentals or purchase of a golf cart is not considered an eligible expense.

SPORTS REGISTRATIONS

League or team registration fees.

NUTRITIONAL COUNSELING

Nutritional Counseling that is received from a licensed or certified nutritionist or dietitian.

ZUMBA

Classes must be with a certified instructor.

KARATE

Classes must be with a certified instructor.

UNDER WEIGHT PROGRAMS

You can use all or any part of your $150 allocation to apply towards program fees. Food is <u>not</u> considered an eligible expense.

POLICE DEPARTMENT FITNESS EQUIPMENT

Employees may pool their available wellness dollars together towards the purchase of fitness equipment to be stored and used in the Police Department fitness room. Once the equipment is purchased, the equipment becomes the property of the City. The equipment must remain on site, and be accessible to any City/County Healthcare Plan member for use. Those choosing to pool their wellness dollars together for this purchase will not be entitled to any refund or reuse of that year’s wellness benefit once the transaction is processed. This eligible expense is only available for equipment purchased for the Police Department fitness room.

Examples of items not allowed under your Wellness Plan include, but are not limited to:

1. Personal exercise equipment
2. Clothing
3. Massage
4. Food
5. Dance Lessons

ARTICLE VII

DEFINITIONS

"BENEFIT PERIOD" means a calendar year commencing each January 1st and terminating each December 31st. The first Benefit Period for the Member will commence on the effective date of the Member's coverage under this Contract and which will terminate on December 31st of the same calendar year or earlier if this Plan is terminated.

"COORDINATION" means if an employee or a dependent have other health plan coverage, including Medicare, claims will be coordinated so that not more than 100 percent of covered charges will be paid. The order of primary responsibility will follow the current National Association of Insurance Commissioners (NAIC) guidelines at the time a claim is incurred. The order of primary responsibility for a covered child shall be that the parent whose birthday is first in the year is "primary" to the plan of the parent whose birthday falls later in the year. In the case of divorced parents who remarry, the plan of the parent with the custody is primary, followed by the plan of the parent not having custody, unless ordered otherwise by a court of appropriate jurisdiction. This Plan will be secondary to any plan, including non-group medical policies, which does not have a coordination of benefits provision.

"COVERED CHARGES" means the amount of the billed charge from a Provider that is considered for reimbursement by the Plan. The Covered Charge for expenses billed shall be the Customary and Reasonable allowed amount as determined by the Claims Administrator.

"COVERED SERVICES" means those Medically Necessary qualifying for payment of benefits under this Plan.

"CREDITABLE COVERAGE" means health benefit coverage provided to an individual prior to enrollment in the Plan. See HIPAA Rules.

"CUSTOMARY AND REASONABLE CHARGE" (CR) means the amount of a charge for Covered Services furnished by a Covered Provider determined by the Claims Administrator using a nationally recognized data base using zip codes to determine the size of the area needed to get an accurate cross section of data.

"The Customary and Reasonable Charge" may exceed the amount determined pursuant to the use of the national data base, if in the reasonable judgment of the Claims Administrator, special consideration is required due to extenuating circumstances, such as unusual complexity of treatment in the case or insufficient data to support a determination of the "Customary" charge. In such cases, the "Customary and Reasonable Charge" will be the charge determined in the judgment of the Claims Administrator to be reasonable in light of the circumstances. The CR schedule may be

replaced by an alternate fee or payment schedule at the discretion of the Claim Administrator, with approval of the Plan Administrator.

"DEPENDENT" means:
A dependent child is eligible under the plan member's coverage if the child has any of the following relationships to the plan member or an enrolled spouse:

- A natural child.
- Legally adopted or placed for adoption (that is, you assume a legal obligation to provide full or partial support and intend to adopt the child).
- A child for whom you have legal guardianship.
- A stepchild.
- A foster child.
- A natural child a court orders to be covered.

A dependent child who has been placed in your home for the purpose of adoption or whom you have adopted is eligible for coverage on the date of placement for adoption or the date of actual adoption, whichever occurs first.

In addition, a dependent child must be one of the following (except for Dental Benefits – see specific eligibility listed below):

- Under age 26.
- Over age 26, unmarried and a full-time student enrolled in an accredited educational institution. Full-time student status continues during regularly scheduled school vacations and during extended absences for up to four months due to a physical or mental disability.
- Totally and permanently disabled, physically or mentally. The disability must have existed before the child turned age 26, or while the child was a full-time student. In addition, the child must have had creditable coverage without a break of 63 days or more since turning the age 26 or since becoming a full-time student.

For Dental and Wrap Plan Benefits only, a dependent child must be:

- Unmarried.
- Under age 25.
- Primarily dependent upon the covered Employee for support and maintenance.

OR

- Unmarried, over age 25, primarily dependent upon the covered Employee for support and maintenance, and a full-time student enrolled in an accredited education institution. Full-time student status continues during regularly schedule school vacation and during extended absences for up to four months due to a physical or mental disability.
- Totally and permanently disabled, physically or mentally. The disability must have existed before the child turned age 25, or while the child was a full-time student. In addition, the child must have had creditable coverage

without a break of 63 days or more since turning age 25 or since becoming a full-time student.

The Plan will not terminate coverage of a dependent child due to a medically necessary leave of absence from, or any other change in enrollment at, a postsecondary education institution that commences while such child is suffering from a serious illness or injury that causes such child to lose student status for purposes of coverage under the plan, before the earlier of: (1) one year after the first day of the medically necessary leave of absence; or (2) the date on which such coverage would otherwise terminate under the terms of the plan. Requires written certification by the child's treating physician. Provides that coverage under this Act continues in the manner in which the participant or beneficiary is covered under the plan changes so long as the change of coverage continues to provide coverage of beneficiaries as dependent children.

Please note: In addition to the preceding requirements, eligibility is affected by coverage enrollment events and coverage termination events (See Article VIII, Term & Termination).

"EMPLOYEE" means an employee of a participating Employer who has met the requirement for participation in the Plan as set out by their Employer.

"EMPLOYER" means any Employer who has submitted all required underwriting information for coverage under the Plan and has been accepted by the Plan as meeting the requirements for participation under the terms of this Plan.

"FAMILY COVERAGE" means coverage for the Employee and each person who qualifies as a Member due to his or her relationship with the Employee.

"MEDICARE" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

"MEMBER" means an eligible Employee and/or Dependent of the Employee who has applied for coverage under the Plan and been accepted by the Plan.

"PHYSICIAN" means a duly licensed Medical Doctor (M.D.), Doctor of Osteopathic Medicine (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Medical Dentistry (D.M.D.), Doctor of Chiropractic Services (D.C.), Doctor of Optometry (O.D.), Doctor of Podiatric Medicine (D.P.M.), Psychologist (Ph.D.) or (Psy.D.).

"PLAN" means this City/County Health Care Plan, effective July 1, 1983, including any amendments attached hereto.

"PLAN ADMINISTRATOR" means the person designated by the City/County Plan Board of Directors. Currently the City Treasurer, City of Burlington Iowa is the designated Plan Administrator.

"PLAN SPONSOR" means the City of Burlington Iowa and the County of Des Moines, Iowa and all participating Governmental Agencies.

"PROVIDER" means any Physician, or person licensed in their state of practice to perform covered services under this Plan and not specifically excluded under the Plan exclusions.

ARTICLE VIII

TERM AND TERMINATION

Termination of Coverage of Eligible Employees and their Dependents. Your coverage under this Plan will terminate at 12:01 a.m. on whichever of the following days occurs first;

a) The last day of the month within which you cease to be an eligible employee;
   - The last day of the month within which any contribution required by you or on your behalf is due and unpaid.
   - The last day of the month immediately following the date we received notice that your coverage is to be terminated.

b) The last day of the month within which you cease to be an eligible dependent;
   - Completion of a dependent's full-time schooling if the dependent is age 26 or older (age 25 for Dental and Wrap Plan benefits – additional eligibility requirements may apply).
   - Death.
   - Dependent child who is not a full-time student or permanently disabled reaches age 26 (age 25 for Dental and Wrap Plan benefits – additional eligibility requirements may apply).
   - Divorce, annulment, or legal separation.
   - Reaching the overall lifetime benefits maximum.

c) The date you enter active duty in the armed forces of any country; or

d) The date the Plan is terminated.

ARTICLE IX

CONTINUATION COVERAGE

What is COBRA?

Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity to elect a temporary extension of health coverage (called "continuation coverage" or "COBRA coverage") in certain instances when coverage under a group health plan would otherwise end. A group health plan includes any major medical plan, dental plan, vision plan, health FSA, or other plan that we may maintain and that provides medical care. For simplicity, any such group health plan is referred to in this section as the "Plan." You do not have to show that you are insurable to elect continuation coverage. However, you will have to pay the entire premium for your continuation coverage. At the end of the maximum coverage period (described below), you will be allowed to enroll in an individual conversion health plan if it is otherwise available under the Plan, subject to the requirement to pay the premiums required by the individual conversion health plan.

Qualifying Events

If you are an ***employee*** of the Employer and are covered by the Plan, you have the right to elect continuation coverage if you lose coverage under the Plan because of any one of the following two "qualifying events":

1. Termination of your employment (for reasons other than gross misconduct).
2. Reduction in the hours of your employment.

If you are the ***spouse*** of an employee covered by the Plan, you have the right to elect continuation coverage if you lose coverage under the Plan because of any of the following four "qualifying events":

1. The death of your spouse.
2. A termination of your spouse's employment (for reasons other that gross misconduct) or reduction in your spouse's hours of employment with the Employer.
3. Divorce or legal separation from your spouse.
4. Your spouse becomes entitled to Medicare benefits.

In the case of a ***dependent child*** of an employee covered by the Plan, the dependent child has the right to elect continuation coverage if group health coverage under the Plan is lost because of any of the following five "qualifying events":

1. The death of the employee-parent.

2. The termination of the employee-parent's employment (for reasons other than gross misconduct) or reduction in the employee-parent's hours of employment with the Employer.
3. Parents' divorce or legal separation.
4. The employee-parent becomes entitled to Medicare benefits.
5. The dependent ceases to be a "dependent child" under the Plan.

Your Important Notice Obligations

If your spouse or dependent child loses coverage under the Plan because of divorce, legal separation or the child's losing dependent status under the Plan, then you (the employee) or your spouse or dependent has the responsibility to notify the Plan Administrator of the divorce, legal separation, or the child's losing dependent status. You or your spouse or dependent *must* provide this notice no later than 60 days after the date coverage terminates under the plan. *If you or your spouse or dependent child fails to provide this notice to the Plan Administrator during this 60-day notice period, any spouse or dependent child who loses coverage will NOT be offered the option to elect continuation coverage.* Furthermore, if you or your spouse or dependent child fails to provide this notice to the Plan Administrator, and if any claims are mistakenly paid for expenses incurred after the date coverage is supposed to terminate upon the divorce, legal separation, or a child's losing dependent status, then you, your spouse and dependent children will be required to reimburse the Plan for any claims so paid.

Election Procedures

You (the employee) and/or your spouse and dependent children must elect continuation coverage within 60 days after Plan coverage ends, or, if later, 60 days after the Plan Administrator provides you or your family member with notice of the right to elect continuation coverage. *If you or your spouse and dependent children do not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage.* A COBRA election mailed to the Plan Administrator is considered to be made on the date of mailing.

You (the employee) and/or your spouse and dependent children may elect continuation coverage for all qualifying family members. You, your spouse and dependent children each have an independent right to elect continuation coverage even if the covered employee does not elect it.

You (the employee) and/or your spouse and dependent children may elect continuation coverage even if covered under another employer-sponsored group health plan or if you are entitled to and are receiving Medicare.

Type of Coverage

The continuation coverage that is offered will be the same coverage that you, your spouse or dependent children had on the day before the qualifying event. Therefore, an employee, spouse, or dependent child who is not covered under the Plan on the day before the qualifying event generally is not entitled to COBRA coverage except, for example, when there is no coverage because it was eliminated in anticipation of a

qualifying event such as divorce. If the coverage is modified for similarly situated employees or their spouses or dependent children, then COBRA coverage will be modified in the same way.

If the Employer maintains more than one group health plan (or offers a choice of separate benefit packages), you (or your spouse or dependent children) may elect COBRA coverage under one or more of those plans in which you have coverage. If a family plan is taken, then all enrolled must be under the same plan of coverage.

If the Employer maintains a health flexible spending arrangement (health FSA) under which you are reimbursed for medical expenses, you (or your spouse or dependent children) may elect to continue the health FSA coverage under COBRA, but only if there is a positive account balance (i.e. year-to-date contributions exceed year-to-date claims) on the day before the qualifying event. COBRA coverage under the health FSA will continue only for the remainder of the Plan year in which the qualifying event occurred. If there is a negative account balance, then no qualified beneficiary may elect COBRA coverage under the health FSA.

COBRA Premiums That You Must Pay

The initial premium must be made within 45 days after the date of the COBRA election by the qualified beneficiary. Payment generally must cover the period of coverage from the date of COBRA election retroactive to the date of the loss of coverage due to the qualifying event. Premiums for successive periods of coverage are due on the 1st of the month with a 30-day grace period for payments. The Plan will not send monthly premium notices.

If you do not make the full premium payment by the due date or within the 30-day grace period, then COBRA coverage will be canceled retroactively to the 1st of the month, with no possibility of reinstatement.

Maximum Coverage Period

The maximum duration for COBRA coverage is described below. COBRA coverage may terminate before the maximum coverage period ends in certain situations (which are described later under the heading "Termination of COBRA Coverage Before the End of the Maximum Coverage Period").

36 months. If you, (the spouse or dependent child), loses group health coverage because of the employee's death, divorce, legal separation, or the employee's becoming entitled to Medicare, or because you lose your status as a dependent child under the Plan, then the maximum coverage period (for spouse and dependent child) is three years from the date of the qualifying event.

18 months. If you, (the employee), lose group health coverage because of the employee's termination of employment (other than for gross misconduct), or reduction in hours, then the maximum continuation coverage period (for the employee, spouse and

dependent child, if applicable) is 18 months from the date of termination or reduction in hours.

29 Months. If an employee or family member is disabled at any time during the first 60 days after the date of termination of employment or reduction in hours, then the continuation coverage period for all qualified beneficiaries under the qualifying event is 29 months from the date of termination or reduction in hours. The Social Security Administration must formally determine under Title II or Title XVI of the Social Security Act that the disability exists and when it began. For the 29-month continuation coverage period to apply, notice of the determination of disability under the Social Security Act must be provided to the Plan Administrator within both the 18-month coverage period and 60 days after the date of determination.

Additional Rules Regarding the 36-month Period. If a second qualifying event that gives rise to a 36-month maximum coverage period for the spouse or dependent child (for example, the employee dies or becomes divorced) occurs within an 18-month or 29-month coverage period, then the 36-month maximum coverage period (for a spouse or dependent child) runs from the date of the initial termination or reduction in hours. For the 36-month maximum coverage period to apply, notice of the second qualifying event must be provided to the Plan Administrator within 60 days after the date of the event. If no notice is given within the required 60-day period, no additional extension of COBRA coverage will occur.

If the qualifying event occurs within 18 months after employee becomes entitled to Medicare, then the maximum coverage period (for the spouse and dependent child) ends thirty-six months from the date the employee became entitled to Medicare.

Shorter Maximum Period for Health FSAs. The maximum COBRA period for a Health Flexible Spending Arrangement (health FSA) maintained by the Employer (if there is a positive account balance as of the date of the qualifying event, as explained above) ends on the last day of the Plan year in which the qualifying event occurred. If there is a negative account balance as of the date of the qualifying event, no COBRA coverage will be offered.

Children Born to or Placed for Adoption With the Covered Employee during COBRA Period

A child born to, adopted by or placed for adoption with a covered employee during a period of continuation coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected continuation coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether though special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the Plan eligibility requirements.

Open Enrollment Rights and HIPAA Special Enrollment Rights

Qualified beneficiaries who have elected COBRA will be given the same opportunity available to similarly situated active employees to change their coverage options or to add or eliminate coverage for dependents at open enrollment (only if the Plan offers an open enrollment). In addition, HIPAA's special enrollment rights will apply to those who have elected COBRA. HIPAA, a federal law, gives a person already on COBRA certain rights to add coverage for dependents if such person acquires a new dependent (through marriage, birth, adoption or placement for adoption), or if an eligible dependent declines coverage because of other coverage and later loses such coverage due to certain qualifying reasons. Except for certain children described above under "Children Born to or Placed for Adoption With the Covered Employee During COBRA Period," dependents who are enrolled in a special enrollment period or open enrollment period do not become qualified beneficiaries – their coverage will end at the same time that coverage ends for the person who elected COBRA and later added them as dependents.

Alternate Recipients Under QMCSOs

If a child of yours (the employee's) is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) at the time of a qualifying event, that child is entitled to the same rights under COBRA as a dependent child of yours, regardless of whether that child would otherwise be considered your dependent.

Termination of COBRA Coverage Before the End of Maximum Coverage Period

Continuation coverage of the employee, spouse and/or dependent child will automatically terminate (before the end of the maximum coverage period) when any one of the following six events occurs:

1. The Employer no longer provides group health coverage to any of its employees.
2. The premium for the qualified beneficiary's COBRA coverage is not paid timely.
3. After electing COBRA, you (the employee, spouse or dependent child) become covered under another group health plan (as an employee or otherwise) that has no exclusion or limitation with respect to any pre-existing condition that you have. If the other plan has applicable exclusions or limitations, then your COBRA coverage will terminate after the exclusion or limitation no longer applies (for example, after a 12-month pre-existing condition waiting period expires) This rule applies only to the qualified beneficiary who becomes covered by another group health plan. (Note that under HIPAA, an exclusion or limitation of the other group health plan might not apply at all to the qualified beneficiary, depending on the length of his or her creditable health plan coverage prior to enrolling in the other group health plan.)
4. After electing COBRA coverage, you (the employee, spouse or dependent child) become entitled to Medicare benefits. This will apply only to the person who becomes entitled to Medicare.
5. You (the employee, spouse or dependent child) become entitled to a 29-month maximum coverage period due to disability of a qualified beneficiary, but then there is a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled (however, continuation coverage will not end until the month that begins more than 30 days after the determination).

6. Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to covered employees or their spouses or dependent children who have coverage under the Plan for a reason other than the COBRA coverage requirements of federal law.

You Must Notify Us About Address Changes, Marital Status Changes, Dependent Status Changes and Disability Status Changes

If your or your spouse's address changes, you *must* promptly notify the Plan Administrator in writing. The Plan Administrator needs up-to-date addresses in order to mail important COBRA notices and other information. Also, if your marital status changes or if a dependent ceases to be a dependent eligible for coverage under the Plan terms, you or your spouse or dependent *must* promptly notify the Plan Administrator in writing (such notification is necessary to protect COBRA rights for your spouse and dependent children). In addition, you must notify us if a disabled employee or family member is determined to be no longer disabled.

Plan Administrator

The Employer is the Plan Administrator. All notices and other communications regarding the Plan and regarding COBRA must be directed to your Employer, in care of **Employee Benefit Systems (EBS),** 214 N. Main Street, Burlington, IA, 52601. Telephone (319) 752-3200, or (800) 373-1327. The Employer has hired EBS to administer claims on its behalf.

Also, please contact your Employer or EBS if you, your spouse or dependent children have any questions concerning COBRA.

ARTICLE X

GENERAL PROVISIONS

Agent for Service of Process and Notice. The Policyholder. The Policyholder is the agent for service of process for the Plan. The Policyholder is the City/County Health Care Plan .

Claims Administrator. Employee Benefit Systems, 214 North Main Street, Burlington, IA 52601, an Iowa Licensed Third Party Administrator. Tell. 319-752-3200 or 1-800-373-1327, FAX 319-752-6114.

Effective Date. This Plan is effective on July 1, 1983, as amended from time to time.

Governing Law. To the extent federal law does not apply, any questions arising under the Plan shall be determined under the laws of the State of Iowa.

Confidentiality. The Employees of Employee Benefit Systems and all health care Providers and their staffs are required by Federal and State laws, staff rules and regulations and a professional code of ethics and conduct to maintain the confidentiality of the Plan's Members and/or their patients. Any breech of a patient's confidentiality should be reported to the Plan Administrator immediately.

The Plan Administrator has the authority to construe the Plan and to determine all questions that arise under it. Such power includes, for example, the administrative discretion necessary to determine whether an individual meets the Plan's written eligibility requirements, or to interpret any other term contained in this Plan document. Further, to the extent that any Plan benefit is subject to a determination of medical necessity, reasonableness or the like, the Claims Administrator will make that factual determination. Interpretations and determinations by the Plan Administrator are binding on all employees, dependents and any beneficiary.

Benefits and Premiums. A member may request information on premium rates and benefit levels available to their Employer.

Department of Labor Notification. The Member may seek information or request assistance from the Department of Labor in regard to the Member's rights under ERISA (Employee Retirement and Income Security Act) and HIPAA (Health Insurance Portability and Accountability Act) by contacting them at:

Department of Labor - PBWA - St. Louis District Office - 815 Olive Street, Room 338 - St. Louis, MO 63101-1559.

ARTICLE XI

CLAIM REVIEW AND APPEAL PROCEDURE

This appeal process is for your dental and wrap plans only.

All dental claims must be appealed through EBS.

The processing of claims broadly includes processing of both requests for service (referrals, authorizations, etc.) and requests for payment of services rendered. This section sets forth the procedure by which the Plan Administrator will review and process initial claims, and review a claimant's appeal of an adverse benefit determination of a claim.

Urgent Care Claims
For purposes of this Plan, an "urgent care claim" is defined as any request for which the time limits to consider a non-urgent claim (described below) could jeopardize the claimant's life, health or ability to regain maximum function, or in the opinion of a physician, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

A claim must be treated as an urgent care claim if a physician with knowledge of the claimant's medical condition indicates the claim is urgent or describes the claims as one where a delay in treatment could seriously jeopardize the claimant's life or health. A claim may also qualify as an urgent care claim in the absence of a physician's recommendation if an individual acting on behalf of the plan, and applying the judgment of a prudent layperson, determines that urgent care is needed.

Time frames for processing urgent care claims are as follows:

- **The initial determination regarding an urgent care claim should be made within 24 hours of receipt of the claim, but not to exceed 72 hours.**

- **If the claimant fails to provide sufficient information regarding an urgent claim, the administrator will be granted a 24-hour extension after receipt of the specific information necessary to complete the claim to make an initial determination of the claim.**

- **If requested by the claimant, a review of a denial of claim that has resulted in an adverse benefit determination must be made within 72 hours of the request for review.**

For purposes of this Plan, an "adverse benefit determination" means a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit under the Plan.

Pre-Service Claims (Non-Urgent)
A Pre-service claim is any request for approval of a benefit with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. Examples of pre-service claims include a request for pre-approval under a utilization review program or a request for prior authorization.

Time frames for processing pre-service claims are as follows:

- **The initial determination regarding a pre-service claim must be made within 15 days of receipt of the claim.**

- **If requested by the claimant, a review of a denial of claim that has resulted in an adverse benefit determination must be made within 30 days of the request for review.**

Post-Service Claims
A post-service claim is any claim that is not a pre-service claim. These are regular claims or requests for payment submitted by providers and patients. Examples of post-service claims include determinations regarding whether a provided service was medically necessary, whether a particular medical service or treatment was appropriately provided for under the plan, or whether the claimant is eligible to be covered under the Plan for the particular medical service or treatment.

Time frames for processing post-service claims are as follows:

- **The initial determination must be made within 30 days of receipt of the claim.**

- **If requested by the claimant, a review of a denial of claim that has resulted in an adverse benefit determination must be made within 60 days of the request for review.**

Note: The times frames listed above for processing pre-service and post-service claims are maximum allowable time frames for processing claims under the Plan. The term days means calendar days. The above time frames apply to properly filed and complete claims only. In the event a claim is not properly filed or is incomplete, notice will be provided (as set out in this document), and the time frames to make a determination will begin with the receipt of the requested information.

Extensions of Time
Limited extensions of time for review of pre-service and post-service claims are permitted. The Plan may extend decision-making at the initial level for both pre-service and post-service claims on a one-time basis for 15 days if the plan administrator determines that such extension is necessary for reasons beyond the control of the Plan.

The Plan Administrator will provide written notice to the claimant prior to the expiration of the initial 15-day period specifying the circumstances requiring the extension and the date by which the plan expects to render a decision. If the reason for the extension is because the claimant did not provide information that is sufficient to determine the claim, the written notice of the extension will describe the information needed to determine the claim. The claimant will have 45 days from the date the notice of extension is provided to respond to the request for additional information.

Concurrent Care Decisions

A concurrent care decision is any decision to reduce or terminate ongoing treatment covering either a period of time or a number of treatments (e.g. a hospital stay, a course of physical therapy, etc.) that has no finite termination date (e.g. covered as long as medically necessary), or a decision regarding an extension of a course of treatment beyond the initially prescribed period of time or number of treatments. The Plan will notify the claimant sufficiently in advance of the reduction or termination to afford the claimant an opportunity to appeal the adverse determination before the treatment is scheduled to be reduced or terminated.

Time frames the Plan Administrator will use for processing concurrent care decisions are as follows:

- **In the event a claimant appeals a concurrent care decision that results in the reduction or termination of benefits previously granted, the Plan Administrator will make a determination of the appeal within 24 hours of the appeal, provided the appeal is made at least 24 hours prior to the expiration of the initially prescribed period or number of treatments.**

- **In the event a claimant requests an extension of a course of treatment, the Plan Administrator will make a determination within 24 hours of the request, provided the request is made at least 24 hours prior to the expiration of the initially prescribed period for the treatment. If such a claim is denied, the claimant has the right to request a review of the denial using the procedures outlined for an urgent care claim.**

Notice Regarding Basis for Adverse Benefit Determinations

The Plan Administrator will notify claimants of the specific basis for an adverse benefit determination. The notice will contain the following information:

- The specific reason or reasons for the adverse determination.

- Reference to the specific Plan provisions on which the determination was based.

- If the adverse benefit determination is based on medical necessity, experimental or investigative treatment, or other similar exclusions or limits, an explanation of the scientific or clinical judgment used by the Plan

Administrator in applying the terms of the Plan to the claimant's medical circumstances, or a statement that such an explanation will be provided free of charge upon the claimant's request.

- A statement that the Plan will provide to the claimant, upon request, any information the Plan has generated or obtained in the process of ensuring and verifying that, in making the particular determination, the Plan complied with its own administrative processes and safeguards that ensure and verify appropriately consistent decision-making in accordance with the Plan's terms.

- Any specific rule, guideline, protocol or other similar criterion that was relied upon in making the denial decision.

- A statement of the Plan's review procedure and time limits for review, including the right to bring a civil lawsuit under ERISA Section 502(a) following a review

- A description of any additional material or information, if any, necessary for the Participant to perfect the claim and an explanation of why such material or information is necessary.

- 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.

Notice Regarding Basis for Appeal Procedure
When a claimant receives an adverse benefit determination, the claimant may appeal the decision. An appeal must be submitted, in writing, no later than 180 days following the claimant's receipt of the notification.

A claimant may submit to the Plan Administrator written comments, documents, records, and other information to support the claimant's appeal of the Claim. The claimant may request that he or she be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. A document, record, or other information shall be considered relevant to a Claim if it:

1. was relied upon in making the benefit determination;
2. was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have applied consistently with respect to all claimants; or

4. constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

If you appeal, the Plan Administrator will review your claim and any additional information you furnish. The review will take into account all relevant information submitted by the claimant, whether or not presented or available at the time of the initial Claim determination.

Normally, the Plan Administrator will decide your appeal within 60 days after it is received. If special circumstances exist with your appeal, the Plan administrator may extend the time period for consideration of your appeal for up to an additional 60 days. If this needs to occur, the Plan Administrator will send you a notice of the extension, indicating the special circumstances requiring the extension and the date by which the review will be concluded.

After your appeal is decided, the Plan Administrator will inform you in writing of its final decision. The decision will contain the Plan provisions upon which the decision was based and instructions for requesting information on which the Plan Administrator based its decision.

You may request a personal appearance before the Claims Administrator. The request for a personal appearance must be made as part of your written appeal to the Plan Administrator. A request for a personal appearance will usually result in an extension of time for the appeal process.

You may authorize one person to represent you regarding communication with the Plan Administrator for specific claims or an appeal. If you decide to make a personal appearance or have another person represent you, it must be done at your expense. This authorization must be made in writing on a form provided by the Plan Administrator and signed by you. You may name only one person as your authorized representative at a time. You may revoke an authorized representative designation at any time.

ARTICLE XII

HIPAA USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use and Disclosure of Protected Health Information. The Plan will use protected health information ("PHI") to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the HIPAA Privacy rules, as amended from time to time. The Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations without the consent of the Plan Participants, including but not limited to disclosures to business associates of the Plan (for example, the third party administrator for the Plan, Employee Benefit Systems).

Notice of HIPAA Privacy Practices. Each Participant will receive a copy of the Plan's Notice of HIPAA Privacy Practices at the time of enrollment. A Participant may request another copy of the Notice by contacting Human Resource.

Disclosures for Treatment. The Plan may use a Participant's PHI to permit the provision, coordination or management of health care and related services. The Plan may disclose PHI to health care providers that are involved in a Participant's care. In addition, the Plan may disclosure of PHI for purposes of consultations and referrals between one or more providers.

Disclosures for Payment Activities. The Plan may disclose a Participant's PHI for purposes of payment under the Plan. Payment activities of the Plan may include activities undertaken by the Plan to determine or fulfill its responsibility for payment of claims for services provided to a Participant, Spouse or Dependent. These activities include, but are not limited to, the following:

- Determination of eligibility, coverage and reimbursement amounts;
- Coordination of benefits between this Plan and other plans providing coverage to Participant;
- Adjudication of benefit claims under the Plan (including claims appeals and other payment disputes);
- Subrogation of claims with other payors;
- Activities related to claims processing;
- Billing, claims management and related claims data processing, including auditing payments, investigating and resolving claim payment disputes and responding to Participant inquiries about payments;
- Obtaining payment under a contract for reinsurance (including stop-loss insurance);
- Medical review of the claim to determine whether charge is medically necessary or customary and reasonable;
- Utilization review, including precertification, preauthorization, concurrent review and retrospective review;

- Disclosure to consumer reporting agencies related to the collection of reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and
- Reimbursement to the Plan.

Health Care Operations Disclosures. The Plan may need to disclose PHI to conduct the health care operations of the Plan. Such disclosures may occur as part of the following activities:

- Quality assessment of the Plan operations or of provider care;
- Activities related to improving health or reducing health care costs for Participants, development of Plan protocols, case management and care coordination for targeted Participants, contacting health care providers and Participants with information about treatment alternatives and related functions;
- Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of insurance for the Plan or a health benefit offered by the Plan;
- Securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance);
- Conducting or arranging for medical review, legal services and auditing functions for the Plan, including compliance programs;
- Business planning and development, such as conducting cost-management and planning analyses related to managing and operating the Plan, and developing and improving payment methods or coverage policies;
- Business management and general administrative activities of the Plan, including but not limited to management activities relating to the implementation of and compliance with HIPAA; and
- Disclosures to third parties in connection with due diligence related to the sale or transfer of assets to a potential successor-in-interest.

Disclosures as Required by Law. The Plan will disclose PHI as required by law and which are permitted or required under the HIPAA Privacy rules. Such disclosures include, but are not limited to, requests for PHI related to worker's compensation claims, to health oversight agencies, in response to lawsuit or administrative agency requests, and to law enforcement officials. Such disclosures are outlined in greater detail in the Plan's Notice of HIPAA Privacy Practices.

Written Authorization to Disclose. The Plan will obtain a written authorization from Participant in the event PHI that requires a written authorization needs to be disclosed by the Plan to the Plan Sponsor or another third party.

Disclosures to Plan Sponsor. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan Sponsor will abide by the following conditions relating to the use and disclosure of PHI. The Plan Sponsor must agree to the following:

- Not to use or further disclose Participants' PHI, other than as permitted or required by this Plan document or as required by law;
- Ensure that any agents, including a business associate, to whom the Plan Sponsor provides PHI which it has received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- Not to use or disclose PHI for employment-related actions and decisions unless authorized in writing by a Participant;
- Not use or disclose PHI in connection with any other benefit offered by or employee benefit plan of the Plan Sponsor unless authorized by a Participant;
- Report to the Plan any use or disclosure of a Participant's PHI that is inconsistent with the uses or disclosures provided for by the Plan or permitted by law of which the Plan Sponsor becomes aware;
- Permit a Participant to inspect and copy PHI retained by the Plan and Plan Sponsor in accordance with HIPAA's access requirements;
- Permit a Participant to request amendment of the Participant's PHI retained by Plan or Plan Sponsor, and incorporate any amendments to, or in the case of a denial of the request, the request to amend, PHI in accordance with HIPAA;
- Provide a Participant with an accounting of PHI disclosures in accordance with HIPAA;
- Provide, upon request of the United States Secretary of Health and Human Services, the internal practices, books and records of the Plan Sponsor relating to the use and disclosure of PHI received from the Plan; and
- If feasible, return or destroy all PHI (in any form, including all copies) received from the Plan when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, the Plan Sponsor shall limit further uses and disclosures to those purposes that make the return or destruction of the PHI not feasible.

Access to PHI by Plan Sponsor. The Plan and Plan Sponsor will take reasonable steps to ensure that Participants' PHI shall be disclosed for the purposes set forth in this section or as required by law. The Plan Sponsor intends to use the PHI disclosed to it by the Plan for purposes of Plan administration. To facilitate the administration of the Plan, the following classifications of Plan Sponsor employees may be given access to PHI: Human Resources Manager, Accounting, CFO, and CEO/President. In addition, the Plan Sponsor may disclose PHI to its accountants, attorneys, the third party administrator of the Plan, insurance brokers or other entities providing quotes for future services to the Plan (including but not limited to insurance products, stop loss insurance, administration services, carve out benefit programs including prescription drug coverage), other health plans that provide health benefits to a Participant for purposes of subrogation and coordination of benefits and all business associates of the Plan. The Plan Sponsor may provide PHI to the above named classes of employees, individuals and entities to permit treatment, payment or health care operations under the Plan (as described above).

Non-Compliant Disclosures of PHI. In the event an employee, individual or entity to whom the Plan Sponsor has disclosed PHI does not comply with the requirements set

forth in this Section, the Plan Sponsor shall report the non compliant activity to the Plan through the Plan's privacy officer. The Plan's privacy offer shall conduct or oversee an investigation into the allegations of improper disclosure. If the improper disclosure is found to have occurred, the privacy officer shall recommend to the Plan Sponsor a procedure that can be implemented to reduce the opportunity for an improper disclosure to occur in the future. The Plan Sponsor may adopt the procedure in whole or in part, and shall take those actions reasonably necessary to ensure that type of improper disclosure does not occur in the future. The privacy officer may also recommend disciplinary sanctions against the non-compliant party, which the Plan Sponsor may implement in whole or in part.

Plan HIPAA Privacy Officer. For purposes of this Plan, the Plan's HIPAA privacy officer shall be Business Manager.

Complaints. In the event a Participant believes the Participant's HIPAA privacy rights have been violated by the Plan, the Participant may file a written complaint with the Plan's privacy officer or with the U.S. Secretary of the Department of Health and Human Services.