

***Plan Document and
Summary Plan Description for the
City of Burlington/County of Des Moines
(COBCO) Major Medical Plan***

EFFECTIVE DATE: 07/01/2017

Introduction

City of Burlington/County of Des Moines (COBCO) (the "Employer" or "Company") is pleased to offer you this benefit plan. It is a valuable and important part of your overall compensation package.

This booklet provides information about your major medical insurance. It serves as the Plan document and the Summary Plan Description ("SPD") for the City of Burlington/County of Des Moines (COBCO) Major Medical Plan ("the Plan"). The information supplements the benefits certificate, benefit summaries, schedule of benefits, Certificate of Coverage and other descriptive documents relating to the Plan. Unless otherwise noted, if there are any conflicts between the terms of this Plan document/SPD and the terms of any benefits certificates or summaries distributed by the insurer of the Plan, the information distributed by the insurer shall control.

We encourage you to read this booklet and become familiar with your benefits. You may also wish to share this information with your enrolled family members.

This SPD and Plan document replace all prior SPDs and Plan documents you may have in your files. Be sure to keep this booklet in a safe and convenient place for future reference.

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Plan Overview

The Plan provides major medical coverage to eligible employees and their dependents through a combination of insurance provided by the insurer selected by the Company ("Insurer") and partial self-funding.

Your Eligibility

You are eligible for major medical coverage if you are a full-time active employee normally scheduled to work 30 hours per week. If you are a Des Moines County Regional Solid Waste Commission Employee, you are eligible to participate under the plan if you are normally scheduled to work 24 hours per week.

Unless otherwise communicated to you by the Company, the following individuals are not eligible for benefits: employees of a temporary or staffing firm, payroll agency, or leasing organization, contract employees, part-time employees, persons hired on a seasonal or temporary basis, and other individuals who are not on the Employer payroll, as determined by the Employer, without regard to any court or agency decision determining common-law employment status.

Eligible Dependents

The definition of eligible dependents and other provisions, such as whether you may enroll your eligible dependents in the Plan, are defined in the insurance certificates. Those provisions, and the definition of a dependent, are incorporated by reference herein.

When Coverage Begins

To be eligible for major medical coverage, you must satisfy the eligibility requirements described in the applicable insurance certificates and other materials provided. Unless otherwise stated in those materials your coverage begins the first of the month following date of hire. Coverage for your eligible dependents begins on the same day as your initial eligibility provided you enroll your dependents within 31 days of eligibility. Certain benefits, such as disability or life insurance, may require you to be actively at work in order to be initially eligible for a Benefit Program and for any change in coverage to take effect. See the materials provided by your Insurer to determine when this applies to you.

Look-back Measurement Method for Determining Full-time Employee Status

The Company uses the look-back measurement method to determine who is a full-time employee for purposes of the Plan's health care benefits. The look-back measurement method is based on Internal Revenue Service (IRS) final regulations.

The look-back measurement method applies to:

- All employees;

The look-back measurement method involves three different periods:

- A measurement period;
- The stability period; and
- An administrative period.

The measurement period is a period for counting your hours of service. Different measurement periods apply to ongoing employees, new employees who are variable hour, seasonal or part-time, and new non-seasonal employees who are expected to work full time.

If you are an ongoing employee, this measurement period is called the "standard measurement period." Your hours of service during the standard measurement period will determine your eligibility for the Plan's health care benefits for the stability period that follows the standard measurement period and any administrative period.

If you are a new employee who is variable hour, seasonal or part-time, this measurement period is called the "initial measurement period." Your hours of service during the initial measurement period will determine your eligibility for the Plan's health care benefits for the stability period that follows the initial measurement period and any administrative period.

If you are a new non-seasonal employee who is expected to work full time, the Company will determine your status as a full-time employee who is eligible for the Plan's health care benefits based on your hours of service for each calendar month. Once you have been employed for a certain length of time, the measurement rules for ongoing employees will apply to you.

The stability period is a period that follows a measurement period. Your hours of service during the measurement period will determine whether you are considered a full-time employee who is eligible for health care benefits during the stability period. As a general rule, your status as a full-time employee or a non-full-time employee is "locked in" for the stability period, regardless of how many hours you work during the stability period, as long as you remain an employee of the Company. There are exceptions to this general rule for employees who experience certain changes in employment status.

An administrative period is a short period between the measurement period and the stability period when the Company performs administrative tasks, such as determining eligibility for coverage and facilitating Plan enrollment. The administrative period may last up to 90 days. However, the initial measurement period for new employees and the administrative period combined cannot extend beyond the last day of the first calendar month beginning on or after the one-year anniversary of the employee's start date (totaling, at most, 13 months and a fraction of a month).

Special rules may apply in certain circumstances, such as when employees are rehired by the Company or return from unpaid leave.

The rules for the look-back measurement method are very complex. Keep in mind that this information is a summary of how the rules work. More complex rules may apply to your situation. The Company intends to follow applicable IRS guidance when administering the look-back measurement method. If you have any questions about this measurement method and how it applies to you, please contact the Plan Administrator.

Proof of Dependent Eligibility

The Employer reserves the right to verify that your dependent is eligible or continues to be eligible for coverage under the Plan. If you are asked to verify a dependent's eligibility for coverage, you will receive a notice describing the documents that you need to submit. To ensure that coverage for an eligible dependent continues without interruption, you must submit the required proof within the designated time period. If you fail to do so, coverage for your dependent may be canceled retroactively.

Your Contribution for Coverage

Each year, the Employer will evaluate all costs and may adjust the cost of coverage during the next annual enrollment. Any required contribution amount will be provided to you by the Employer in your enrollment materials. You may also request a copy of any required contribution amounts from the Plan Administrator.

For most benefits you pay the employee cost of Plan premiums through pre-tax payroll deductions each pay period; however, some Benefit Programs may require premiums to be paid with after-tax dollars.

Enrolling for Coverage

New Hire Enrollment

As a newly eligible employee, you will receive an Election Form and enrollment information when you first become eligible for benefits. You will need to make your coverage elections by the deadline shown in your enrollment materials. When you enroll in the Plan, you authorize the Employer to deduct any required premiums from your pay through salary reduction.

The elections you make will remain in effect until the next open enrollment, unless you have a qualifying change in status. After your initial enrollment, you will enroll during the designated annual open enrollment period. If you do not enroll for coverage when initially eligible, you will be deemed to have elected no coverage or the default coverage designated by the Employer.

Annual Open Enrollment Period

Each year during a designated open enrollment period, you will be given an opportunity to make your elections for the upcoming year. Your enrollment materials and Election Form will provide the options available to you and your share of the premium cost, as well as any default coverage you will be deemed to have elected if you do not make an election by the specified deadline. The elections you make will take effect on July 1 and stay in effect through June 30, the Plan Year, unless you have a qualifying change in status. The Plan Year may differ from the policy year of an insured benefit, with deductible and out-of-pocket expenses based on the policy year. You should refer to the insurance certificate and other materials provided by the Insurer to determine if a different policy year applies.

Qualifying Change in Status

If you experience a change in certain family or employment circumstances that results in you or a covered dependent gaining or losing eligibility under a health plan, you can change your coverage to fit your new situation without waiting for the next annual open enrollment period.

As defined by Internal Revenue Code Section 125, or the regulations thereunder, the following events may be considered a change in status:

- your marriage;
- the birth, adoption, or placement for adoption of a child;
- your death or the death of your spouse or other eligible dependent;
- your divorce, annulment, or legal separation;
- a change in a dependent child's eligibility;

-
- a change in employment status for you or your spouse that affects benefits (including termination or commencement of employment, strike or lockout, or commencement of or return from an unpaid leave of absence);
 - a change in your Employer work location or home address that changes your overall benefit options and/or prices;
 - employee's spouse's open enrollment period differs and employee needs to make changes to account for other coverage;
 - a significant change in coverage or the cost of coverage;
 - a reduction or loss of your or a dependent's coverage under this or another plan; or
 - a court order, such as a QMCSO or NMSN, that mandates coverage for an eligible dependent child;
 - change in employment status to less than 30 hours of service per week on average even if reduction does not result in loss of Plan eligibility;
 - eligibility for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace or seeking to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period;

If you experience a change in certain family or employment circumstances, you can change your coverage. Changes in your election must be consistent with your change in status event. For example, if you get married, you may change your coverage level from you only to you and your spouse. If you move, and your current coverage is no longer available in the new area, you may change your coverage option.

You should report a status change to the Plan Administrator as soon as possible, but no later than 31 days after the event occurs.

Keep in mind that certain mid-year election change events do not apply to health Flexible Spending Accounts (FSAs), such as cost or coverage changes. Contact the Plan Administrator if you have questions about when you can change your elections.

When Coverage Ends

Except as otherwise provided in the insurance certificate, your coverage under this Plan ends on the last day of the month in which your employment terminates. Coverage may be extended under certain circumstances, such as when you take an approved leave of absence.

Coverage for your covered dependents ends on the date your coverage ends, or, if earlier, on the last day of the month in which your dependent is no longer eligible for coverage under the Plan.

Coverage will also end for you and your covered dependents as of the date the Employer terminates this Plan or, if earlier, the effective date you request coverage to be terminated for you and/or your covered dependent.

Cancellation of Coverage

If you fail to pay any required premium for coverage under the Plan, coverage for you and your covered dependents will be canceled for that Plan and no claims incurred after the effective date of cancellation will be paid.

Coverage While Not at Work

In certain situations, coverage may continue for you and your dependents when you are not at work, so long as you continue to pay your share of the cost. If you take an unpaid leave of absence, you will need to make payment arrangements prior to the start of your leave. Your payments will be made on an after-tax basis, unless you are on paid leave, in which case your premium payments will continue to be deducted on a pre-tax basis. You should discuss with Human Resources or your supervisor what options are available for paying your share of costs while you are absent from work.

If You Take a Leave of Absence (FMLA)

If you take an approved FMLA leave of absence, your coverage will continue for the duration of your leave, as long as you continue to pay your share of the cost as required under the Employer's FMLA Policy.

Benefits

The Plan provides major medical benefits as outlined in the insurance certificates and summaries distributed by the Insurer. The Plan is fully-insured and benefits are paid for by the Insurer. For the current Plan Year the Company has decided to partially self-fund the Plan and to supplement the benefits provided by the Insurer as outlined in Exhibit A ("Partially Self Funded Benefits").

How to File a Claim

Claims for benefits under the Plan should be filed as outlined in the insurance certificates and summaries distributed by the Insurer. For Partially Self Funded Benefits, when you (or your medical provider) submit eligible medical expenses incurred during a coverage period to the Insurer, claims will automatically be made to the Company's Claims Administrator for determination of coverage and payment, if applicable. Claims will be handled in accordance with the claims procedures outlined in the insurance certificate and summaries provided by the Insurer. To the extent a claim is denied, you may appeal the denial in accordance with the procedures outlined in the insurance certificate and summaries provided by the Insurer. If the Claim pertains solely to Partial Self-Funding Benefits than the appeal should be directed to the Claims Administrator.

Benefit Payment

When you file a claim, the Insurer or Claims Administrator, as applicable, will make payment directly to the provider.

When Participation Ends

Your participation in the Plan ends at the end of the month in which your employment terminates or if you fail to pay any required premium contribution.

Health Care Flexible Spending Account and PSF

The PSF is different from a Health Care Flexible Spending Account even though both may reimburse similar expenses. If you participate in both a Health Care Flexible Spending Account and a PSF, eligible expenses will be first reimbursed through the PSF.

Administrative Information

The following sections contain legal and administrative information you may need to contact the right person for information or help. Although you may not use this information often, it can be helpful if you want to know:

- how to contact the Plan Administrator;
- how to contact the Insurer or Claims Administrators;
- what to do if a benefit claim is denied; and
- your rights under Federal laws such as COBRA.

IMPORTANT: This Summary Plan Description may not include language or certain mandated coverage required by state insurance laws. State mandated coverage may be addressed separately in the insurance certificates provided by the Insurer.

Plan Sponsor and Administrator

City of Burlington/County of Des Moines (COBCO) is the Plan Sponsor and the Plan Administrator for this Plan. You may contact the Plan Administrator at the following address and telephone number:

Plan Administrator

City of Burlington/County of Des Moines (COBCO)
400 Washington Street
Burlington, IA 52601
319-753-8178

The Plan Administrator will administer this Plan and will be the "Named Fiduciary" for the Plan. The Plan Administrator will have control of the day-to-day administration of this Plan and will serve without additional remuneration if such individual is an employee of the Employer. The Plan Administrator will have the following duties and authority with respect to the Plan:

- To prepare and file with governmental agencies all reports, returns, and all documents and information required under applicable law;
- To prepare and furnish appropriate information to eligible employees and Plan participants;
- To prescribe uniform procedures to be followed by eligible employees and participants in making elections, filing claims, and other administrative functions in order to properly administer the Plan;
- To receive such information or representations from the Employer, eligible employees, and participants necessary for the proper administration of the Plan and to rely on such information or representations unless the Plan Administrator has actual knowledge that the information or representations are false;
- To properly administer the Plan in accordance with all applicable laws governing fiduciary standards; and
- To maintain and preserve appropriate Plan records.

In addition, the Plan Administrator has the discretionary authority to determine eligibility under all provisions of the Plan; correct defects, supply omissions, and reconcile inconsistencies in the Plan; ensure that all benefits are paid according to the Plan; interpret Plan provisions for all

participants and beneficiaries; and decide issues of credibility necessary to carry out and operate the Plan.

For fully insured benefits, unless otherwise expressly provided in the insurance policy or contract, the Insurer shall be the Named Fiduciary only with respect to the benefits provided through the insurance policy or contract. The Insurer shall be responsible for determining eligibility for and the amount of benefits payable under the Benefit Program, and for prescribing claims procedures to be followed by Participants. The Insurer shall also be responsible for paying claims.

Plan Year

The Plan Year is July 1 through June 30.

Type of Plan

This Plan is called a "welfare plan", which includes group health plans; they help protect you against financial loss in case of sickness or injury.

Identification Numbers

The Employer Identification Number (EIN) is:

EIN: 47-3024022

Plan Funding and Type of Administration

Funding and administration of the Plan is as follows.

| | |
|------------------------|---|
| Type of Administration | The Plan is administered by the Employer through an arrangement with Insurers and third-party (claims) administrators. Insured benefits will be payable solely by the Insurer. |
| Funding | The Employer and employees both contribute to the Plan. Premiums are paid to the Insurers for fully insured Benefit Programs and benefits will be paid by the Insurer in accordance with the applicable insurance contract/policy. The Partial Self Funding benefits is paid for from the Company's general assets. |

Insurers/Claims Administrators

The Insurer is responsible for administering benefits and paying claims, except for those claims covered by the Partial Self Funding Benefits. The Company has contracted with a separate Claims Administrator to process Partial Self Funding Benefits. You may contact the Insurer or Claims Administrator directly, using the information listed below.

While these service providers make every attempt to provide accurate information, mistakes can occur. It is important to understand that Federal law requires that the Plan Documents always control, even if their terms conflict with information given to you by an Insurer or other service provider.

Claims Administrator for Partial Self Funding Benefits:

Employee Benefit Systems
214 North Main Street
PO Box 1053
Burlington, IA 52601
800-373-1327
www.ebs-tpa.com

Insurer:

Wellmark
1331 Grand Avenue
PO Box 9232
Des Moines, IA 50306
www.wellmark.com

Agent for Service of Legal Process

Service of Legal Process may be served upon:

Director of Administrative Services

City of Burlington/County of Des Moines (COBCO)

400 Washington Street

Burlington, IA 52601

319-753-8178

Service of Legal Process may also be served on the Plan Administrator.

No Obligation to Continue Employment

The Plan does not create an obligation for the Employer to continue your employment or interfere with the Employer's right to terminate your employment, with or without cause.

Non-Alienation of Benefits

With the exception of a Qualified Medical Child Support Order, your right to any benefit under this Plan cannot be sold, assigned, transferred, pledged or garnished. The Plan Administrator or, where applicable, the Insurer, has procedures for determining whether an order qualifies as a QMCSO; participants or beneficiaries may obtain a copy without charge by contacting the Plan Administrator or Insurer.

Severability

If any provision of this Plan is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions shall continue to be fully effective.

Payment of Benefits to Others

The Insurer or Claims Administrator, as applicable, in its discretion, may authorize any payments due to be paid to the parent or legal guardian of any individual who is either a minor or legally incompetent and unable to handle his or her own affairs.

Expenses

All expenses incurred in connection with the administration of the Plan, are Plan expenses and will be paid from the general assets of the Company.

Fraud

No payments under the Plan will be made if you or a provider of services attempts to perpetrate a fraud upon the Plan with respect to any such claim. The Insurer or Claims Administrator will have the right to make the final determination of whether a fraud has been attempted or committed upon the Plan or if a misrepresentation of fact has been made. The Plan will have the right to recover any amounts, with interest, improperly paid by the Plan by reason of fraud. If you or a covered dependent attempts or commits fraud upon the Plan, your coverage may be terminated and you may be subject to disciplinary action by the Employer, up to and including termination of employment.

Indemnity

To the full extent permitted by law, the Company will indemnify the Plan Administrator and each other employee who acts in the capacity of an agent, delegate, or representative ("Plan Administration Employee") of the Plan Administrator against any and all losses, liabilities, costs and expenses incurred by the Plan Administration Employee in connection with or arising out of any pending, threatened, or anticipated action, suit or other proceeding in which the Employee may be involved by having been a Plan Administration Employee.

Future of the Plan

The Company has the sole right to amend, modify, suspend, or terminate all or part of the Plan at any time.

The Company may also change the level of benefits provided under the Plan at any time. If a change is made, benefits for claims incurred after the date the change takes effect will be paid according to the revised Plan provisions. In other words, once a change is made, there are no rights to benefits based on earlier Plan provisions.

Adoption of the Plan

The City of Burlington/County of Des Moines (COBCO) Major Medical Plan, effective 07/01/1983, as amended and restated herein, is hereby adopted as of 07/01/2017. This document constitutes the basis for administration of the Plan.

IN WITNESS WHEREOF, the parties have caused this document to be executed on this 8th day of June, 2017.

BY Bucky Perry

TITLE: Board President

CITY OF BURLINGTON/COUNTY OF DES MOINES (COBCO) PARTIAL SELF-FUNDING BENEFITS

07/01/2017

The Partial Self Funding Benefits will pay the difference between the deductible and out-of-pocket maximums provided by the major medical plan so that the participant realizes the following:

Plan A

Calendar Year Deductible:

| | |
|------------|-------|
| Per Person | \$100 |
| Per Family | \$200 |

Out-of-Pocket Calendar Year Maximums:

| | |
|------------|---------|
| Per Person | \$650 |
| Per Family | \$1,300 |

Co-insurance:

| | |
|----------------|-------|
| In-Network | 90/10 |
| Out-of-Network | 80/20 |

Additional Details:

Drug deductible and co-pay amounts, where applicable, do not apply towards the medical out-of-pocket-maximum.

Deductible amounts you pay during the last three months of a benefit year carry over as credits to meet your deductible for the next benefit year. These credits do not apply toward your out-of-pocket maximum.

Plan B

Calendar Year Deductible:

| | |
|------------|-------|
| Per Person | \$250 |
| Per Family | \$500 |

Out-of-Pocket Calendar Year Maximums:

| | |
|------------|---------|
| Per Person | \$1,000 |
| Per Family | \$2,000 |

Co-insurance:

| | |
|----------------|-------|
| In-Network | 90/10 |
| Out-of-Network | 80/20 |

Additional Details:

Drug deductible and co-pay amounts, where applicable, do not apply towards the medical out-of-pocket-maximum.

Deductible amounts you pay during the last three months of a benefit year carry over as credits to meet your deductible for the next benefit year. These credits do not apply toward your out-of-pocket maximum.

Plan C

Calendar Year Deductible:

| | |
|------------|---------|
| Per Person | \$500 |
| Per Family | \$1,000 |

Out-of-Pocket Calendar Year Maximums:

| | |
|------------|---------|
| Per Person | \$1,500 |
| Per Family | \$3,000 |

Co-insurance:

| | |
|----------------|-------|
| In-Network | 90/10 |
| Out-of-Network | 80/20 |

Additional Details:

Drug deductible and co-pay amounts, where applicable, do not apply towards the medical out-of-pocket-maximum.

Deductible amounts you pay during the last three months of a benefit year carry over as credits to meet your deductible for the next benefit year. These credits do not apply toward your out-of-pocket maximum.

Plan D

Calendar Year Deductible:

| | |
|------------|---------|
| Per Person | \$1,000 |
| Per Family | \$2,000 |

Out-of-Pocket Calendar Year Maximums:

| | |
|------------|---------|
| Per Person | \$2,000 |
| Per Family | \$4,000 |

Co-insurance:

| | |
|----------------|-------|
| In-Network | 90/10 |
| Out-of-Network | 80/20 |

Additional Details:

Drug deductible and co-pay amounts, where applicable, do not apply towards the medical out-of-pocket-maximum.

Deductible amounts you pay during the last three months of a benefit year carry over as credits to meet your deductible for the next benefit year. These credits do not apply toward your out-of-pocket maximum.

Plan E

Calendar Year Deductible:

| | |
|------------|---------|
| Per Person | \$2,000 |
| Per Family | \$4,000 |

Out-of-Pocket Calendar Year Maximums:

| | |
|------------|---------|
| Per Person | \$4,000 |
| Per Family | \$8,000 |

Co-insurance:

| | |
|----------------|-------|
| In-Network | 90/10 |
| Out-of-Network | 80/20 |

Additional Details:

Drug deductible and co-pay amounts, where applicable, do not apply towards the medical out-of-pocket-maximum.

Deductible amounts you pay during the last three months of a benefit year carry over as credits to meet your deductible for the next benefit year. These credits do not apply toward your out-of-pocket maximum.

The Partial Self Funding Benefits cover only those items and services determined by the Insurer to be covered services under the Plan.

