

***Plan Document and
Summary Plan Description for the
City of Bettendorf Self-Insured Vision Plan***

- Vision Benefits

Effective Date: 03/01/2016

Introduction

City of Bettendorf (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 describes your vision benefits and serves as the Summary Plan Description (SPD) and Plan document for the City of Bettendorf Self-Insured Vision Plan (“the Plan”).

This document sets forth the provisions of the Plan that provide for payment or reimbursement of Plan benefits.

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 Plan and SPD replace all previous booklets 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

Your Eligibility

You are eligible for benefits if you are:

- A full-time active employee normally scheduled to work a minimum of 30 hours per week;
- On the regular payroll of the Company; and
- In a class of employees eligible for coverage.

Unless otherwise communicated to you in writing by the Company, the following individuals are not eligible for benefits: employees of a temporary or staffing firm, payroll agency or leasing organization, independent contractors and other individuals who are not on the Company payroll, as determined by the Company, without regard to any court or agency decision determining common-law employment status.

Eligible Dependents

You may enroll your eligible dependents on your coverage. Your eligible dependents include:

- your legal spouse;
- your common law spouse;
- your child under age 26 regardless of financial dependency, residency with you, marital status, or student status;
- your unmarried child of any age who is principally supported by you and who is not capable of self-support due to a physical or mental disability that began while the child was covered by the Plan; or
- your unmarried child of any age who is not capable of self-support due to a physical or mental disability that occurred before age 26, whose disability is continuous, and who is principally supported by you.

“Principally supported by you” means that the child is dependent on you for more than one-half of his or her support, as defined by Code Section 152 of the Internal Revenue Code.

For purposes of the Plan, your child includes:

- your biological child;
- your legally adopted child (including any child lawfully placed for adoption with you);
- your stepchild;
- a child for whom you are the court-appointed legal guardian;
- child over 26 if unmarried and full-time student; and
- an eligible child for whom you are required to provide coverage under the terms of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN).

An eligible dependent does not include a person enrolled as an employee under the Plan or any person who is covered as a dependent of another employee covered under the Plan. If you and your spouse are both employed by the Company, each of you may elect your own

coverage (based on your own eligibility for benefits) or one of you may be enrolled as a dependent on the other's coverage, but only one of you may cover your dependent children. It is your responsibility to notify the Company if your dependent becomes ineligible for coverage.

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.

When Coverage Begins

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:

- Measurement period
- Stability period
- 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.

For You

Your health care coverage begins the 31st day after date of hire and after you meet all eligibility requirements.

If you terminate employment and are subsequently rehired, you will be treated as a new employee and will need to satisfy all eligibility requirements in order to be covered under the Plan.

For Your Dependents

Coverage for your eligible dependents begins on the same day as your initial eligibility provided you timely enroll your dependents in coverage.

If you acquire a new dependent through marriage, birth, adoption or placement for adoption, you can add your new dependent to your coverage as long as you enroll the dependent within 31 days of the date on which they became eligible. If you wait longer than 31 days, you may be required to wait until the Plan’s next open enrollment period to enroll your new dependent for coverage.

Charges for nursery or physician care will be initially applied toward the plan of the covered parent. If the newborn child is not enrolled in the Plan on a timely basis, the covered parent will be responsible for all costs.

Your Cost for Coverage

Both the Company and you share in the cost of your health care benefits. Each year, the Company will evaluate all costs and may adjust the cost of coverage during the next annual enrollment. Your enrollment materials will show the coverage categories available to you.

You pay your portion of this cost through pre-tax payroll deductions taken from your pay each pay period. Your actual cost is determined by the coverage you select and the number of dependents you cover. You must elect coverage for yourself in order to cover your eligible dependents.

Enrolling for Coverage

New Hire Enrollment

As a newly eligible employee, you will receive enrollment information when you first become eligible for benefits. To enroll in vision coverage, 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 Company to deduct any required premiums from your pay.

The elections you make will remain in effect until the next June 30, 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 only be eligible for the default coverages designated by the Plan Administrator, as shown in your enrollment materials.

You will automatically receive identification (ID) cards for you and your eligible dependents when your enrollment is processed.

Annual Open Enrollment

Each year during a designated open enrollment period, you will be given an opportunity to make your elections for the upcoming year. Your open enrollment materials 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 the following July 1 and stay in effect through June 30, unless you have a qualifying change in status.

Effect of Section 125 Tax Regulations on this Plan

It is intended that this Plan meets the requirements of the Internal Revenue Code Section 125 and the regulations thereunder and that the qualified benefits which you may elect are eligible for exclusion from income. The Plan is designed and administered in accordance with those regulations. This enables you to pay your share of the cost for coverage on a pre-tax basis. Neither the Company nor any fiduciary under the Plan will in any way be liable for any taxes or other liability incurred by you by virtue of your participation in the Plan.

Because of this favorable tax-treatment, there are certain restrictions on when you can make changes to your elections. Generally, your elections stay in effect for the Plan Year and you can make changes only during each annual open enrollment. However, at any time throughout the year, you can make changes to your coverage within 31 days following:

- The date you have a qualifying change in status as described below;

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- The date you meet the Special Enrollment Rights criteria described below.

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 the Internal Revenue Service (IRS), status changes applicable to health care coverage include:

- 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 due to age or eligibility for other coverage;
- 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);
- 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;
- a court order, such as a QMCSO or NMSN, that mandates coverage for an eligible dependent child;

If you experience a change in certain family or employment circumstances, you can change your coverage. Changes must be consistent with status changes as described above. 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 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.

Special Enrollment Rights

If you decline enrollment for yourself or your dependents (including your spouse) because you have other health coverage, you may be able to enroll yourself and your dependents in this Plan, if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However,

you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

You or an affected eligible dependent may also enroll in coverage if eligibility for coverage is lost under Medicaid or the Children's Health Insurance Program (CHIP), or if you become eligible for premium assistance under Medicaid or CHIP. You must enroll under this Plan within 60 days of the date you lose coverage or become eligible for premium assistance.

This "special enrollment right" exists even if you previously declined coverage under the Plan. You will need to provide documentation of the change. Contact the Plan Administrator to determine what information you will need to provide.

When Coverage Ends

Your coverage under this Plan ends on the last day of the month in which your employment terminates or you cease to be an eligible employee unless benefits are extended as described below.

Coverage for your covered dependents ends when 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 Company terminates this Plan or, if earlier, the effective date you request termination of coverage for you and your covered dependents.

If your coverage under the Plan ends for reasons other than the Company's termination of all coverage under the Plan, you and/or your eligible dependents may be eligible to elect to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) as described below.

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 and no claims incurred after the effective date of cancellation will be paid.

Rescission of Coverage

Coverage under the Plan may be rescinded (canceled retroactively) if you or a covered dependent performs an act, practice or omission that constitutes fraud, or you make an intentional misrepresentation of material fact as prohibited by the terms of the Plan. A rescission of coverage is an adverse benefit determination that you may dispute under the Plan's claims and appeals procedures. If your coverage is being rescinded due to fraud or intentional misrepresentation of material fact, you will receive at least 30 days' advance written notice of the rescission. This notice will outline your appeal rights under the Plan. Benefits under the Plan that qualify as "excepted benefits" under HIPAA are not subject to these restrictions on when coverage may be rescinded. Some types of retroactive terminations of coverage are permissible even when fraud or intentional misrepresentation are not involved. Coverage may be retroactively terminated for failure to timely pay required premiums or contributions as required by the Plan.

Also, coverage may be retroactively terminated to the date of your divorce if you fail to notify the Plan of your divorce and you continue to cover your ex-spouse under the Plan. Coverage

will be canceled prospectively for errors in coverage or if no fraud or intentional misrepresentation was made by you or your covered dependent.

The Plan reserves the right to recover from you and/or your covered dependents any benefits paid as a result of the wrongful activity that are in excess of the contributions paid. In the event the Plan terminates or rescinds coverage for gross misconduct on your behalf, continuation coverage under COBRA may be denied to you and your covered dependents.

Coverage While Not at Work

In certain situations, health care 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 continue to be paid while you are absent from work, any premium payments will continue to be deducted from your pay on a pre-tax basis. If you are not receiving your pay during an absence, you will need to make arrangements for payment of any required premiums. You should discuss with your supervisor what options are available for paying your share of costs while you are absent from work.

If You are Totally Disabled

If you become totally disabled, your health care coverage may continue for If employee is totally disabled, coverage continues until the last day of the month of the termination date. Extension of coverage will be based on COBRA regulations, concurrent with any leave that is designated as FMLA, as long as you continue to pay your share of the cost. Coverage will run concurrently with COBRA coverage.

If You Are Temporarily Laid Off

If you are laid off for a temporary period of time, your health care coverage will continue through the end of the month in which your layoff begins.

If You Take a Leave of Absence – FMLA

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

If You Take a Leave of Absence – Non-FMLA

If you take an approved leave of absence (paid or unpaid), your coverage will continue during your leave, provided you continue to pay your share of the cost.

If You Take a Military Leave of Absence

If you are absent from work due to an approved military leave, health care coverage may continue for up to 24 months under both the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and COBRA, which run concurrently, starting on the date your military service begins.

If You Are Permanently Laid Off

If you are permanently laid off (separated from service), your health care coverage will continue through the end of the month in which your layoff begins.

Your Vision Benefits

The Plan provides vision care benefits that cover vision examinations, eyeglasses, and corrective lenses for you and your covered dependents. The Summary of Vision Benefits chart below shows the covered services under the Plan. You must elect coverage in order to be covered. Your enrollment materials will show the options available to you and the cost for coverage, if applicable.

The Plan will pay for Covered Expenses for vision care incurred by a Covered Person, subject to any required Deductible, Co-pay if applicable, Plan Participation amount, maximums, and limits show on the Schedule of Benefits. Benefits are based on the Usual and Customary charge, the maximum fee schedule, or the Negotiated Rate.

Your benefits include one vision examination every other benefit period. Contact lenses and frames are available once every other benefit period.

Summary of Vision Benefits

SERVICE OR MATERIALS	BASIC VISION PLAN (PLAN PAYS)
Vision Examination To Age 19 (once every 24 months)	Up to \$75 per person. Plan pays 80% after maximum.
Vision Examination From Age 19 (once every 24 months)	Up to \$75 per person
Hardware* To Age 19	Up to \$400 per person every 24- month period. Plan pays 80% after maximum.
Hardware* From Age 19	Up to \$400 per person every 24 month period

*Frames; lenses (single, bifocal, trifocal, lenticular, progressive); elective contacts; contact lenses fitting fee; safety lens & frames; sunglasses or subnormal vision aids

Coverage includes necessary professional services, such as prescribing/ordering proper lenses, contact lens evaluation fee, assistance in the selection of frames, verifying the accuracy of finished lenses, proper fitting and adjustment of frames or contact lenses, and progress or follow-up work as necessary.

Vision Exclusions

The following list includes some common vision expenses which are not covered under the Plan:

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- Orthoptics or vision training and any associated supplemental testing;
 - Plano lenses (nonprescription);
 - The fitting and/or dispensing of non-prescription glasses or vision devices, whether or not prescribed by a Physician or optometrist;
 - Correction of visual acuity or refractive errors;
 - Aniseikonia;
 - Refraction;
 - Vision therapy services (including orthoptics) or supplies;
 - Eye surgeries used to improve or correct eyesight for refractive disorders including LASIK surgery, radial keratotomy, refractive keratoplasty, or similar surgery;
 - Two pairs of glasses in lieu of bifocals;
 - Cosmetic lenses;
 - Services or processes for cosmetic purposes;
 - Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available;
 - Medical or surgical treatment of the eyes;
 - Services or materials provided as a result of any workers' compensation law or similar legislation, or obtained through or required by any government agency or program (Federal, state, or any subdivision thereof);
 - Charges for frames received before two calendar years from your last date of service for a frame;
 - Charges for vision and supplies that are covered by your medical coverage;
 - Experimental services and supplies; or
 - Replacement of lost, stolen, or broken lenses or frames.

For More Information

If you have a question about your vision benefits, or for more information about a specific procedure described above, contact your Claims Administrator.

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 Claims Administrators;
- what to do if a benefit claim is denied; and
- your rights under Federal laws such as COBRA.

Plan Sponsor and Administrator

City of Bettendorf is the Plan Sponsor and the Plan Administrator for this Plan. You may contact the Plan Administrator at the following address and telephone number:

City of Bettendorf
1609 State Street
Bettendorf, IA 52722
563-344-4009

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 Company. 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 Company, 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;
- 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. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

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) and Plan number for the Plan is:

EIN: 42-6004276

Plan Funding and Type of Administration

Funding and administration of the Plan is as follows.

Type of Administration	Benefits are self-funded and are administered through contracts with third-party administrators.
Funding	The Company and employees both contribute to the Plan. The Company will use these contributions to pay benefits to or on behalf of Plan Participants from the Company’s general assets. Employee contributions toward the cost of a particular benefit will be used in their entirety prior to using Company contributions to pay for the cost of such benefit.

Claims Administrators

The Plan Administrator has contracted with the following company(ies) to administer benefits and pay claims. You may contact the appropriate Claims Administrator directly, using the information listed below. Your Claims Administrator is listed on your ID card.

The Plan Administrator has also contracted with different third-party administrators, to handle certain day-to-day administrative functions such as utilization review, provider contracting and prescription benefit management for the Plan. While these service providers make every attempt to provide accurate information, mistakes can occur. It is important to understand that the Plan documents always control, even if their terms conflict with information given to you by a service provider.

Vision Administrator

City of Bettendorf
1609 State Street
Bettendorf, IA 52722
563-344-4009
www.bettendorf.org

Agent for Service of Legal Process

If any disputes arise under the Plan, papers may be served upon:

Human Resources Director
City of Bettendorf
1609 State Street
Bettendorf, IA 52722
563-344-4009

Service of legal process also can be made upon the Plan Administrator.

No Obligation to Continue Employment

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

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

All benefits are payable when the Plan Administrator receives written proof of loss. Benefits will be payable to the covered participant, unless otherwise assigned. If you receive care from a non-network provider, it is your responsibility to pay the non-network provider for the charges you incurred, including any difference between what you were billed and what the Plan paid. You may not assign your benefits under the Plan to a non-network provider without the Company's consent. The Company (or a Claims Administrator) reserves the right, in its discretion, to pay a non-network provider directly for services rendered to you. Direct payment to a non-network provider shall not be deemed to constitute consent by the Company or waive the consent requirement for assigning benefits.

Payment of Benefits to Others

The Plan Administrator, 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 the participant or the provider of services attempts to perpetrate a fraud upon the Plan with respect to any such claim. The Plan 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. Any employee or his or her covered dependent who attempts or commits fraud upon the Plan may have their coverage terminated and may be subject to disciplinary action by the Company, 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.

Compliance with Federal Mandates

The Plan is designed to comply to the extent possible with the requirement of all applicable laws, including but not limited to: COBRA, USERRA, HIPAA, the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), WHCRA, FMLA, the Mental Health Parity and Addiction Equity Act of 2008, PPACA, HITECH, Michelle's Law, and Title I of GINA.

Non-discrimination

In accordance with IRC Section 125, the Plan is intended not to discriminate in favor of Key Employees (as defined in Code Section 416) or Highly Compensated Individuals as to eligibility to participate; or in favor of Highly Compensated Participants as to contributions and benefits, nor to provide more statutory nontaxable benefits than permitted under applicable law to Key Employees. The Plan Administrator will take such actions necessary to ensure that the Plan does not discriminate in favor of Key Employees, Highly Compensated Individuals, or Highly Compensated Participants.

Future of the Plan

The Company expects that the Plan will continue indefinitely. However, 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.

Claims Procedures

This section describes what you must do to file or appeal a claim for services received in- and out-of-network.

Time Frames for Processing a Claim

Claims are divided into urgent care claims, concurrent care claims, pre-service health claims, and post-service health claims. If you or your representative fail to follow the Plan's procedures for filing a claim or if you file an incomplete claim, the Plan will notify you or your representative of the failure according to the time frames shown in the following chart.

If an initial claim is denied in whole or in part, you or your representative will receive written notice from the Plan Administrator. This notice will include the reasons for denial, the specific Plan provision involved, an explanation of how claims are reviewed, the procedure for requesting a review of the denied claim, a description of any additional material or information that must be submitted with the appeal, and an explanation of why it is necessary. If your claim for benefits is denied, you or your representative may file a written appeal for review of a denied claim with the Plan Administrator.

The chart below shows the time frames for filing different types of claims with the Plan. If you have any questions about what type of claim you may have or the timing requirements that apply to your claim, please contact your Claims Administrator at the number shown on your ID cards.

Time Frames for Processing a Claim

Claim Process	Urgent Care Claim	Concurrent Care Claim	Pre-Service Health Claim	Post-Service Health Claim
Claims Administrator determines initial claim is improperly filed (not filed according to Plan procedures) or is not complete	Within 24 hours after receipt of improper or incomplete claim (notification may be oral unless you or your representative request otherwise)	Within 24 hours after receipt of request for extension of urgent concurrent care	Within 5 days after receipt of improper or incomplete claim (notification may be oral unless you or your representative request otherwise)	Not applicable
Claims Administrator determines that you must submit additional information required to complete claim	Within 48 hours after receipt of notice that your claim is incomplete	Not applicable	Within 45 days after receipt of notice that additional information is required	Within 45 days after receipt of notice that additional information is required
Claims Administrator reviews claim and makes determination of:		For urgent care claims, within 24 hours after receipt of the claim, provided request is submitted at least 24 hours prior to expiration of prescribed period of time or number of treatments. If not submitted within 24 hours prior to expiration of prescribed period of time or number of treatments, not later than 72 hours after receipt of claim.* For non-urgent care claims, determination will be made within time frame designated for type of claim (pre- or post-service) and prior to expiration of prescribed period of time or number of treatments.*		
complete/proper claim	Within 48 hours after the earlier of: receipt of requested information, or at end of period allowed for you to provide information		Within 15 days after the earlier of: receipt of requested information, or at end of 45-day period allowed for you to provide information	Within 30 days after the earlier of: receipt of requested information, or at end of 45-day period allowed for you to provide information
initial claim	Within 24 hours of receipt of initial claim		Within 15 days of date initial claim is received	Within 30 days of date initial claim is received
Extension period,** if required due to special circumstances beyond control of Claims Administrator	Not applicable	Not applicable	Additional 15 days if Plan requires more information from you and provides an extension notice during initial 15-day period	Additional 15 days if Plan requires more information from you and provides an extension notice during initial 30-day period

* A request for extension of treatment will be deemed to be an initial claim. A reduction or termination of approved, ongoing treatment will be deemed to be an adverse claim decision. If the Claims Administrator makes an adverse decision, you will be notified of the reduction/termination within a time frame that allows you to submit an appeal and have a determination on the appeal prior to the expiration of the prescribed period of time or number of treatments.

** Whenever an extension is required, the Plan must notify you before the current determination period expires. The notice must state the circumstances requiring the extension and the date a determination is expected to be made.

How to Appeal a Claim

To appeal a denied claim or to review administrative documents pertinent to the claim, you or your representative must send a written request to the Plan. You may also appeal the Plan's decision to rescind your coverage due to fraud or intentional misrepresentation of material fact. The time frames for appealing a claim are shown in the following chart.

If you or your representative submit an appeal, state why you think your claim should be reviewed and include any data, documents, questions, or comments, along with copies of itemized bills and claim forms relating to your claim. You may request, free-of-charge, copies of all documents, records, and other information relevant to your claim. A reviewer who did not make the initial claim determination will be responsible for reviewing your appeal. Also, you will be notified of any expert advice obtained on behalf of the Plan in reviewing the denied claim, regardless of whether such advice was relied upon in reviewing your claim. Such experts will not be individuals who were consulted in making the initial claim determination.

<i>Time Frames for Appealing Denied Claims</i>				
Appeal Process	Urgent Care Claim	Concurrent Care Claim	Pre-Service Health Claim	Post-Service Health Claim
You may submit an appeal of denied initial claim to the Claims Administrator	Within 180 days of receiving notice of denied claim	You will be notified of reduction or termination of benefit in time to submit appeal and receive determination before benefit ends	Within 180 days of receiving notice of denied claim	Within 180 days of receiving notice of denied claim
Claims Administrator reviews your first appeal and makes determination	Within 72 hours after appeal is received	Prior to reduction or termination of benefit	Within 15 days of date appeal is received	Within 30 days of date appeal is received
You may submit a second appeal to the Plan Administrator	N/A	N/A	Within 180 days of receiving notice of denied claim	Within 180 days of receiving notice of denied claim
The Plan Administrator reviews your second appeal and makes final determination	N/A	N/A	Within 15 days of date appeal is received	Within 30 days of date appeal is received

You will be notified of the Plan Administrator's decision in writing. If your claim is denied, the Plan Administrator will give you in writing the specific reason(s) that your claim was denied, the specific reference to the Plan provisions on which the denial was based, any internal rules, guidelines, protocols, or similar criteria used as basis for the decision, a statement that you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

The decision of the Plan Administrator shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law.

Exhaustion Required

If you do not file a claim, follow the claims procedures, or appeal a claim within the timeframes permitted, you will give up all legal rights, including your right to file suit, as you will not have exhausted your internal administrative appeal rights. Participants or claimants

must exhaust all remedies available to them under the Plan before bringing legal action. Additionally, legal action may not be brought against the Plan more than one year after a final decision on appeal has been reviewed under the Plan.

Coordination of Benefits

This section describes how benefits under this Plan are coordinated with other benefits to which you or a covered dependent might be entitled.

Non-Duplication of Benefits / Coordination of Benefits

If a Plan participant is covered by another employer's plan, the two plans work together to avoid duplicating payments. This is called non-duplication or coordination of benefits.

Your medical benefits are coordinated with benefits from:

- other employers' plans;
- certain government plans; and
- motor vehicle plans when required by law.

Non-duplication of benefits does not apply to prescription drug benefits.

How Non-Duplication Works

When an expense is covered by two plans, the following apply:

- the primary plan is determined and pays the full amount it normally would pay;
- the secondary plan calculates the amount it normally would pay and then pays any portion of that amount not paid by the primary plan (but not to exceed 100% of charges); and
- you pay any remaining expenses.

If another plan is primary and this plan is secondary, the Plan will calculate the amount it would pay as if there were no other coverage, subtract the amount payable by the primary plan, and then pay any eligible remaining amount.

Determining Primary and Secondary Plans

Primary and secondary plans are determined as follows.

- A plan that does not contain a coordination of benefits provision is primary.
- If you are the employee, this Plan normally is primary when you have a covered expense.
- If your covered spouse is the patient, your spouse's company plan (if applicable) is primary. Your spouse should submit expenses to that plan first, wait for the payment, and then submit the claim under this Plan with copies of the expenses and the primary plan's Explanation of Benefits (EOB).
- When both parents' plans cover an eligible dependent child, the plan of the parent whose birthday (month and day) comes first in the calendar year is primary. For example, if your spouse's birthday is March 15 and your birthday is September 28, your spouse's plan is primary. If both parents were born on the same day, the plan of the parent who has had coverage in effect the longest will be primary. However, if the other plan does not have this birthday rule and, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits.
- When parents who are legally separated or divorced both cover an eligible dependent child, the following rules apply.

- If the parents have joint custody and there is no court decree stating which parent is responsible for health care expenses, the birthday rule previously stated will apply.
- If one parent has custody, his or her plan is primary and the other parent's plan is secondary. If the parent with custody remarries, the stepparent's plan becomes secondary and will pay before the plan of the parent without custody (the third plan).
- If the remarried parent with custody has no health care coverage, the stepparent's plan is primary and the plan of the parent without custody is secondary.
- Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses and that parent has enrolled the child in his or her plan, that parent's plan is primary.
- When none of the previous rules applies, the plan that has covered the patient for the longer period is primary.

Coordination with Medicare

If you are actively employed after becoming eligible for Medicare, your coverage under the Plan will be coordinated with Medicare. Which plan pays first ("primary") is determined by whether your Employer is considered a small or large group employer. Generally, for large group employer plans, Medicare requires the employer's plan to pay first and Medicare pays second ("secondary"). You should check with your Employer if you become eligible for Medicare while employed to determine if your Employer's coverage will be primary or secondary.

The Plan also coordinates with Medicare as follows.

- End-stage renal disease—If you or a covered dependent is eligible for Medicare due to end-stage renal disease, this Plan will be primary for the first 30 months of dialysis treatment; after this period, this Plan will be secondary to Medicare for this disease only.
- Mandated coverage under another group plan—If a person is covered under another group plan and Federal law requires the other group plan to pay primary to Medicare, this Plan will be tertiary (third payer) to both the other plan and Medicare.

Coordination with Auto Insurance Plans

First-party auto insurance coverage is considered primary. This Plan coordinates its benefits with the first-party benefits from an auto insurance plan without regard to fault for the same covered expense.

If you or your covered dependent incurs covered expenses as a result of an automobile accident (either as driver, passenger, or pedestrian), the amount of covered expenses that the Plan will pay is limited to:

- any deductible under the automobile coverage;
- any co-payment under the automobile coverage;

- any expense properly denied by the automobile coverage that is a covered expense; and
- any expense that the Plan is required to pay by law.

For Maximum Benefit

Generally, claims should be filed promptly with all plans to receive the maximum allowable benefits. You must supply the claim information needed to administer coordination of benefits. If you receive more payment than you should when benefits are coordinated, you will be expected to repay any overpayment.

Subrogation and Reimbursement

If you or your dependent receives benefits in excess of the amount payable under the Plan, the Company has a right to subrogation and reimbursement, as defined in the following sections.

Right of Recovery

The Plan has the right to recover benefits it has paid on your or your dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- advanced during the time period you were meeting the calendar year deductible; or
- advanced during the time period you were meeting the out-of-pocket maximum for the calendar year.

Benefits paid because you or your dependent misrepresented facts also are subject to recovery. If the Plan provides a benefit for you or your dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested; or
- reduce a future benefit payment for you or your dependent by the amount of the overpayment.

Right to Subrogation

The right to subrogation means the Plan is substituted to any legal claims that you may be entitled to pursue for benefits that the Plan has paid. Subrogation applies when the Plan has paid benefits for a sickness or injury for which a third party is considered responsible (e.g., an insurance carrier if you are involved in an auto accident).

The Plan will be subrogated to, and will succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100 percent of any services and benefits the Plan has paid on your behalf relating to any sickness or injury caused by any third party.

Right to Reimbursement

The right to reimbursement means that if a third party causes a sickness or injury for which you receive a settlement, judgment, or other recovery, you must use those proceeds to return to the Plan 100 percent of any benefits you received for that sickness or injury.

Third Parties

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a sickness, injury, or damages, or who is legally responsible for the sickness, injury, or damages; or
- any person or entity who is or may be obligated to provide you with benefits or payments under:
 - underinsured or uninsured motorist insurance;
 - medical provisions of no-fault or traditional insurance (auto, homeowners, or otherwise);
 - Workers' Compensation coverage; or
 - any other insurance carrier or third party administrator.

When This Provision Applies To You

If you or any of your covered dependents, or anyone who receives benefits under this plan, becomes ill or is injured and is entitled to receive money from any source, including but not limited to any party's liability insurance or uninsured/underinsured motorist proceeds, then the benefits provided or to be provided by the Plan will be paid only if you fully cooperate with the terms and conditions of the Plan.

As a condition of receiving benefits under this Plan, you agree that acceptance of benefits for you and/or your dependents is constructive notice of this provision in its entirety and agree to reimburse the Plan 100 percent of any benefits provided or to be provided without reduction for attorney's fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. You further agree that the Plan shall have an equitable lien on any funds received by you or your dependents, and/or you or your attorney, if any, from any source for any purpose and shall be held in trust until such time as the obligation under this provision is fully satisfied. If you or your dependent retains an attorney, then you and your dependents agree to only retain one who will not assert the Common Fund or Made-Whole Doctrines. Reimbursement shall be made immediately upon collection of any sum(s) recovered regardless of its legal, financial or other sufficiency. If the injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision regardless of state law and/or whether the minor's representative has access or control of any recovery funds.

You or your covered dependent agrees to sign any documents requested by the Plan including but not limited to a reimbursement and/or subrogation agreement, or accident questionnaire, as the Plan or its agent(s) may request. You and your covered dependent also agree to furnish any other information as may be requested by the Plan or its agent(s). Failure to sign and return any requested documentation or information may result in the Plan's denial of claims. However, such failure or refusal to execute such agreements or furnish information does not preclude the Plan from exercising its right to subrogation or obtaining full reimbursement. Any settlement or recovery received, regardless of how characterized, shall first be deemed for reimbursement of expenses paid by the Plan. Any excess after 100 percent reimbursement to the Plan may be divided between you or your dependent (the covered person) and your attorney if applicable. Any accident-related claims made after satisfaction of this obligation shall be paid by you or your dependent and not the Plan.

You and/or your covered dependents agree to take no action which in any way prejudices the rights of the Plan. If it becomes necessary for the Plan to enforce this provision by initiating any action against you or your dependent (the covered person), then you and/or your dependent agree to pay the Plan's attorney's fees and costs associated with the action regardless of the action's outcome.

The Plan Administrator has sole discretion to interpret the terms of this provision in its entirety and reserves the right to make changes as it deems necessary. Furthermore, the Plan may reduce or deny any future benefits by the amount of any recovery received, but not reimbursed, by you or your covered dependent for an accident or injury for which the Plan paid benefits.

If you and/or your covered dependent take no action to recover money from any source, then you and/or your dependent agree to allow the Plan to initiate its own direct action for reimbursement.

Your HIPAA/COBRA Rights

Health Insurance Portability and Accountability Act (HIPAA)

Title II of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations at 45 CFR Parts 160 through 164 (HIPAA) contain provisions governing the use and disclosure of Protected Health Information (PHI) by group health plans, and provide privacy rights to participants in those plans. These rules are called the HIPAA Privacy Rules.

You will receive a “Notice of Privacy Practices” from the Administrator(s) and/or Insurer(s) that contains information about how your individually identifiable health information is protected under the HIPAA Privacy Rules and who you should contact with questions or concerns.

The HIPAA Privacy Rules apply to group health plans. These plans are commonly referred to as “HIPAA Plans” and are administered to comply with the applicable provisions of HIPAA. PHI is individually identifiable information created or received by HIPAA Plans that relates to an individual’s physical or mental health or condition, the provision of health care to an individual, or payment for the provision of health care to an individual. Typically, the information identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper or oral. When PHI is in electronic form it is called “ePHI.”

The HIPAA Plans may disclose PHI to the Plan Sponsor only as permitted under the terms of the Plan, or as otherwise required or permitted by HIPAA. The Plan Sponsor agrees to use and disclose PHI only as permitted or required by the HIPAA Privacy Rules and the terms of the Plan.

The HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose enrollment and disenrollment information to the Plan Sponsor. Also, the HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the information for the purposes of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending or terminating the Plan. “Summary Health Information” means information that summarizes the claims history, claims expenses or types of claims experienced by individuals covered under the HIPAA Plans and has almost all individually identifying information removed. The HIPAA Plans may also disclose PHI to the Plan Sponsor pursuant to a signed authorization that meets the requirements of the HIPAA Privacy Rules.

In addition, the HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose PHI to the Plan Sponsor for plan administration purposes. Plan administration purposes means administration functions performed by the Plan Sponsor on behalf of the HIPAA Plans, such as claims processing, coordination of benefits, quality assurance, auditing and monitoring. Plan administration purposes do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor or any employment-related actions or decisions.

The Plan Sponsor agrees that with respect to any PHI (other than enrollment/disenrollment information, Summary Health Information and information disclosed pursuant to a valid HIPAA authorization) disclosed to it by the HIPAA Plans (or an Insurer with respect to the HIPAA Plans), the Plan Sponsor will:

- Not use or further disclose the information other than as permitted or required by the Plan or as required by law;
- Ensure that any agents, including subcontractors, to whom it provides PHI received from the HIPAA Plans agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;
- Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- Report to the HIPAA Plans any use or disclosure of PHI of which it becomes aware that is inconsistent with the permissible uses or disclosures;
- Make PHI available in accordance with the individual rights of access under the HIPAA Privacy Rules;
- Make an individual's PHI available for amendment, and incorporate any amendments, as required by the HIPAA Privacy Rules;
- Make available the information required to provide an accounting of disclosures to individuals, as required by the HIPAA Privacy Rules;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the HIPAA Plans available to the Secretary of the Department of Health and Human Services for purposes of determining compliance with HIPAA's requirements;
- If feasible, return or destroy all PHI received from the HIPAA Plans that the Plan Sponsor still maintains in any form and retain no copies of this information when no longer needed for the purpose for which disclosure was made, except that, if this return or destruction is not feasible, limit further uses or disclosures to those purposes that make the return or destruction of the information infeasible; and
- Ensure adequate separation between the HIPAA Plans and the Plan Sponsor is established.

In addition, the Plan Sponsor will reasonably and appropriately safeguard ePHI (other than enrollment/disenrollment information, Summary Health Information and information disclosed pursuant to a valid HIPAA authorization) that is created, received, maintained or transmitted to or by the Plan Sponsor on behalf of the HIPAA Plans. The Plan Sponsor will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains or transmits on behalf of the HIPAA Plans;
- Ensure that adequate separation between the HIPAA Plans and the Plan Sponsor is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the information; and
- Report to the HIPAA Plans any security incident of which it becomes aware.

Continuing Health Care Coverage through COBRA

In special situations, you or your covered dependent(s) may continue health care coverage at your or your dependent's expense when it otherwise would end. The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows a continuation of health care coverage to qualified beneficiaries for a specific length of time. This section provides an overview of COBRA continuation coverage. The coverage described may change as permitted or required by applicable law. When you first enroll in coverage, you will receive from the Plan Administrator/COBRA Administrator your initial COBRA notice. This notice and subsequent notices you receive will contain current requirements applicable for you to continue coverage. The length of COBRA continuation coverage (COBRA coverage) depends on the reason that coverage ends, called the "qualifying event." These events and the applicable COBRA continuation period are described below.

If you and/or your eligible dependent(s) choose COBRA coverage, the Company is required to offer the same medical and prescription drug coverage that is offered to similarly situated employees. Proof of insurability is not required to elect COBRA coverage. In other words, you and your covered dependents may continue the same health care coverage you had under the Plan before the COBRA qualifying event.

If you have a new child during the COBRA continuation period by birth, adoption, or placement for adoption, your new child is considered a qualified beneficiary. Your new child is entitled to receive coverage upon his or her date of birth, adoption, or placement for adoption, provided you enroll the child within 30 days of the child's birth/adoption/placement for adoption. If you do not enroll the child under your coverage within 30 days, you will have to wait until the next open enrollment period to enroll your child.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

For more information about the Marketplace, visit www.HealthCare.gov.

COBRA Qualifying Events and Length of Coverage

Each person enrolled in benefits will have the right to elect to continue health benefits upon the occurrence of a qualifying event that would otherwise result in such person losing health benefits. Qualifying events and the length of COBRA continuation are as follows:

18-Month Continuation

Health care coverage for you and your eligible dependent(s) may continue for 18 months after the date of the qualifying event if your:

- employment ends for any reason other than gross misconduct; or
- hours of employment are reduced.

18-Month Continuation Plus 11-Month Extension

If you or your eligible dependent is disabled at the time your employment ends or your hours are reduced, the disabled person may receive an extra 11 months of coverage in addition to the 18-month continuation period (for a total of 29 months of coverage). If the individual entitled to the disability extension has non-disabled family members who have COBRA coverage due to the same qualifying event, those non-disabled family members will also be entitled to the 11-month extension, including any child born or placed for adoption within the first 60 days of COBRA coverage.

The 11-month extension is available to any COBRA participant who meets all of the following requirements:

- he or she becomes disabled before or within the first 60 days of the initial 18-month coverage period; and
- he or she notifies the Plan Administrator (or its designated COBRA Administrator) within 60 days of the date on the Social Security Administration determination letter, and provides a copy of the disability determination; and
- he or she notifies the Plan Administrator (or its designated COBRA Administrator) before the initial 18-month COBRA coverage period ends.

You must also notify the Plan Administrator (or its designated COBRA Administrator) within 30 days of the date Social Security Administration determines that you or your dependent is no longer disabled.

36-Month Continuation

Coverage for your eligible dependent(s) may continue for up to 36 months if coverage is lost due to your:

- death;
- divorce or legal separation;
- eligibility for Medicare coverage; or
- dependent child's loss of eligible dependent status under this Plan

Note: If any of these events (other than Medicare entitlement) occur while your dependents are covered under COBRA (because of an 18-month or 18-month plus extension qualifying event), coverage for the second qualifying event may continue for up to a total of 36 months from the date of the first COBRA qualifying event. In no case, however, will COBRA coverage be continued for more than 36 months in total.

If you become eligible for Medicare before a reduction in hours or your employment terminates, coverage for your dependents may be continued for up to 18 months from the date of your reduction in hours or termination of employment, or for up to 36 months from the date you became covered by Medicare, whichever is longer.

COBRA Notifications

If you or your covered dependents lose coverage under the Plan because your employment status changes, you become entitled to Medicare, or you die, the Plan Administrator (or its designated COBRA administrator) will automatically provide you or your dependents with additional information about COBRA continuation coverage, including what actions you must take by specific deadlines.

If your covered dependent loses coverage as a result of your divorce, legal separation or a dependent child's loss of eligibility under the Plan, you or your dependent must notify the Company within 60 days of the qualifying event. The Plan Administrator (or its designated COBRA administrator) will automatically send you or your dependent, as applicable, COBRA enrollment information. If you or your dependent fails to provide notification of the event within 60 days, you or your dependent forfeits all continuation of coverage rights under COBRA. To continue COBRA coverage, you and/or your eligible dependents must elect and pay the required cost for COBRA coverage.

Cost of COBRA Coverage

You or your eligible dependent pays the full cost for health care coverage under COBRA, plus an administrative fee of two percent, or 102 percent of the full premium cost, except in the case of an 11-month disability extension where you must pay 150 percent of the full premium cost for coverage.

COBRA Continuation Coverage Payments

Each qualified beneficiary may make an independent coverage election. You must elect COBRA coverage by completing and returning your COBRA enrollment form as instructed in your enrollment materials within 60 days of the date you receive information about your COBRA rights or, if later, the date of your qualifying event.

The first COBRA premium payment is due no later than 45 days from the date COBRA coverage is elected. Although COBRA coverage is retroactive to the date of the initial qualifying event, no benefits will be paid until the full premium payment is received. Each month's premium is due prior to the first day of the month of coverage. You or your dependent is responsible for making timely payments.

If you or your dependent fails to make the first payment within 45 days of the COBRA election, or subsequent payments within 30 days of the due date (the grace period), COBRA coverage will be canceled permanently, retroactive to the last date for which premiums were paid. COBRA coverage cannot be reinstated once it is terminated. Other important information you need to know about the required COBRA coverage payments follows.

COBRA premium payments that are returned by the bank for insufficient funds will result in termination of your COBRA coverage if a replacement payment in the form of a cashier's check, certified check, or money order is not made within the grace period.

COBRA premium payments must be mailed to the address indicated on your premium notice. Even if you do not receive your premium notice, it is your responsibility to contact the COBRA administrator. Your COBRA coverage will end if payment is not made by the due date on your notice. It is your responsibility to ensure that your current address is on file.

You may be eligible for state or local assistance to pay the COBRA premium. For more information, contact your local Medicaid office or the office of your state insurance commissioner.

How Benefit Extensions Impact COBRA

If you have a qualifying event that could cause you to lose your coverage, the length of any benefit extension period is generally considered part of your COBRA continuation coverage

period and runs concurrently with your COBRA coverage. (Also see “Coverage While You Are Not at Work” in the Plan Overview for additional information.)

If you take a leave under the Family and Medical Leave Act (FMLA), COBRA begins;

- at the end of the leave if you do not return after the leave; or
- on the date of termination if you decide to terminate your employment during the leave.

When COBRA Coverage Ends

COBRA coverage for a covered individual will end when any of the following occur:

- The premium for COBRA coverage is not paid on a timely basis (monthly payments must be postmarked within the 30-day grace period, your initial payment must be postmarked within 45 days of your initial election).
- The maximum period of COBRA coverage, as it applies to the qualifying event, expires.
- The individual becomes covered under any other group medical plan.
- The individual becomes entitled to Medicare.
- The Company terminates its group health plan coverage for all employees.
- Social Security determines that an individual is no longer disabled during the 11-month extension period.

Definitions

COBRA

The Consolidated Omnibus Budget Reconciliation Act. This Federal law allows a continuation of health care coverage in certain circumstances.

Deductible

The dollar amount (for individual or family) a participant must pay each year before the Plan begins to pay benefits.

Doctor/Physician

A doctor of medicine (M.D.) or doctor of osteopathy (D.O.). The term also includes a chiropractor (D.C.), dentist (D.M.D. or D.D.S.), or a podiatrist (D.P.M.). In all cases, the person must be legally qualified and licensed to perform a service at the time and place of the service.

Employee

A person who works for the Company in an employer-employee relationship.

Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) is a Federal law that provides for an unpaid leave of absence for up to 12 weeks per year for:

- the birth or adoption of a child or placement of a foster child in a participant's home;
- the care of a child, spouse or parent (not including parents-in-law), as defined by Federal law, who has a serious health condition;
- a participant's own serious health condition; or
- any qualifying exigency arising from an employee's spouse, son, daughter, or parent being a member of the military on "covered active duty". Additional military caregiver leave is available to care for a covered service member with a serious injury or illness who is the spouse, son, daughter, parent, or next of kin to the employee.

Generally, you are eligible for coverage under FMLA if you have worked for your Company for at least one year; you have worked at least 1,250 hours during the previous 12 months; your Company has at least 50 employees within 75 miles of your worksite; and you continue to pay any required premium during your leave as determined by the Company. You should contact the Company with any questions you have regarding eligibility for FMLA coverage or how it applies to you.

Genetic Information

Genetic information includes information about genes, gene products, and inherited characteristics that may derive from an individual or family member. This includes information regarding carrier status or information derived from laboratory tests that identify mutations in specific genes or chromosomes, medical examinations, family histories, or direct analysis of genes or chromosomes.

GINA

The Genetic Information Nondiscrimination Act of 2008, as amended.

HIPAA

Health Insurance Portability and Accountability Act of 1996, as amended.

HITECH

The Health Information Technology for Economic and Clinical Health Act, as amended.

Leased Employee

Leased employee as defined in the Internal Revenue Code, section 414(n), as amended.

Managed Care

A type of health care delivery system that combines doctor choice and access with lower costs, less paperwork, and prescribed standards for medically necessary treatment.

Medicare

The program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

Network

A group of doctors, hospitals, and other providers contracted by the Plan to provide health care services for the Plan's members at agreed-upon rates.

NMHPA

The Newborns' and Mother's Health Protection Act of 1996, as amended. Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Out-of-Pocket Maximum

The maximum amount a participant pays for covered medical expenses (including expenses for covered dependents) in a Plan year. When the out-of-pocket maximum is reached, the Plan pays 100% of eligible covered expenses for the rest of the calendar year.

Participant

An eligible employee who elects to participate in the Plan by completing the necessary enrollment forms.

PPACA

The Patient Protection and Affordable Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010.

Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN)

Any court order that: 1) provides for child support with respect to the employee's child or directs the employee to provide coverage under a health benefit plan under a state domestic relations law, or 2) enforces a law relating to medical child support described in the Social Security Act, Section 1908, with respect to a group health plan. A QMCSO or an NMSN also may be issued through an administrative process established under state law. A participant must notify the Plan Administrator if he or she is subject to a QMCSO or an NMSN.

Totally Disabled

An employee who is unable to perform the regular duties of his or her own occupation due to illness or injury shall be considered totally disabled.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

A Federal law covering the rights of participants who have a qualified uniformed services leave.

WHCRA

The Women's Health and Cancer Rights Act of 1998, as amended. Your medical coverage under the Plan includes coverage for a medically necessary mastectomy and patient-elected reconstruction after the mastectomy. Specifically, for you or your covered dependent who is receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for: 1) All stages of reconstruction of the breast on which the mastectomy was performed; 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; 3) Prosthesis; and 4) Treatment of physical complications at all stages of mastectomy, including lymphedema.

Adoption of the Plan

The City of Bettendorf Self-Insured Vision Plan, as stated herein, is hereby adopted as of 03/01/2016. This document constitutes the basis for administration of the Plan.

IN WITNESS WHEREOF, the parties have caused this document to be executed on this 20 day of March, ~~2016~~ 2017.

BY: Kathleen M. Richter

TITLE: Human Resources Director

Update to the City of Bettendorf Vision Plan

This is a Summary of Material Modification that reflects an amendment made to the City of Bettendorf Vision Plan. You should keep it with your City of Bettendorf Vision Plan Document and Summary Plan Description for future reference.

Plan Amendment #1

Effective 07/01/2017, the section of your Plan Document and Summary Plan Description titled "Claims Procedures" has been revised to include the following:

Timely Filing

To be eligible for reimbursement under the Plan, a claim must be submitted within 365 days after the date services were incurred. Claims filed after that time may be denied. If you are unable to file a claim within the prescribed time frame, the Plan Administrator may elect to approve the claim after reviewing any extenuating circumstances if the claim is filed as soon as possible.

The Plan Document and Summary Plan Description will be amended to reflect this change. All other terms and conditions of the plan which are not affected by this Amendment remain unchanged.

Accepted:
City of Bettendorf
Amendment #1 – July 1, 2017

By: Kathleen M. Richler

Title: HR Director

Date: 7-25-17