



CITY OF URBANDALE

NON-UNION EMPLOYEE BENEFIT PLAN

August 1, 2011

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SUMMARY PLAN DESCRIPTION

This booklet contains a general description of benefits available under the Plan and is written to help participants understand them. The details of coverage are limited to the terms and conditions specified in this document which is intended to serve as both the Summary Plan Description and Plan Document. This document will now be referred to as the Plan. The Plan may be examined or copies may be obtained at any time. It is on file with the City of Urbandale.

This Plan was established for the exclusive benefit of the employees of the City of Urbandale with the intention it will continue indefinitely. However, the City of Urbandale reserves the right to amend, modify or terminate this Plan at any time without prior notice to the Plan participants. Any amendment or modification will be in writing, effected through a written resolution signed by the City Manager of the City of Urbandale and will be binding. If this Plan is terminated, participants may not receive benefits, for claims incurred on or after the effective date of termination.

In addition, this Plan may not discriminate against any participant based on: health status; medical condition (including both physical and mental illnesses); claims experience; receipt of health care; medical history; genetic information; medical evidence of good health (including participation in certain dangerous recreational activities and conditions arising out of acts of domestic violence); and disability, as mandated by the Health Insurance Portability and Accountability Act of 1996.

Based on the factors described above, this Plan may not require any individual (as a condition of enrollment or continued enrollment under this Plan) to pay a premium or contribution which is greater than the premium or contribution paid by a similarly situated individual enrolled in this Plan. Nothing in the preceding sentence will be construed: (a) to restrict the amount that may be charged for coverage under this Plan; or (b) to prevent this Plan from establishing premium discounts or rebates or modifying otherwise applicable coinsurance amounts, co-pays or deductibles in return for adherence to programs of health promotion and disease prevention.

INTRODUCTION

This Plan is designed to cover participants various health care expenses. This is a self-funded Plan of benefits which provides coverage for the health care needs of each covered person.

It is important each participant understands this Plan in order to use it effectively. Each participant is encouraged to take the time to read this booklet to gain a basic understanding of the benefits. The "Benefit Summary" which follows provides a brief review of the allowable benefits. The "What Are Covered Benefits?" section provides greater detail regarding the participant's benefits. The Medical Exclusion section outlines care not covered by this Plan.

If the participant has any questions about this Plan of benefits, he/she may contact First Administrators, Inc. Correspondence can be mailed to:

First Administrators, Inc.
P.O. Box 9900
Sioux City, IA 51102-0479

Nationwide 1-800-410-4136
Sioux City..... 712-279-8806

PPO INTRODUCTION

This Plan features a preferred provider organization. The preferred provider organization utilizes a network of hospitals and physicians who have contracts to offer their services at a discounted rate.

The preferred provider network's goal is to contain spiraling health care costs through utilization management and to do this without sacrificing the quality or the comprehensive nature of the benefits provided to the participant. Participating physicians must follow specific guidelines and when applicable, utilize outpatient services whenever possible, eliminate unnecessary inpatient hospital stays, and make wise use of outpatient diagnostic testing and second surgical opinions. A directory of these providers can be furnished, without charge.

Participants always have freedom of choice. The services of any covered provider may be used. However, if participants go to a physician or hospital affiliated with the preferred provider network, the out-of-pocket costs may be less. Please refer to the benefit summary for specific information.

SELECTFIRSTTM

SelectFirstTM is a fee-for-service Preferred Provider Organization (PPO) designed to provide quality care for the participant and his/her dependents, and to help control the rising costs of health care. This Plan has elected to provide health care services through the SelectFirstTM Program. Contracting physicians, hospitals and their staffs have agreed to comply with certain benefit management provisions and in return, participants are directed to them through incentives built into this Plan. A directory of these providers can be furnished, without charge.

The SelectFirstTM area includes the state of Iowa and the contiguous counties in the states surrounding Iowa. To locate a provider, please go to www.firstadministrators.com.

PROTECTED HEALTH INFORMATION

PLAN SPONSOR'S CERTIFICATION OF COMPLIANCE

The Company is the Plan Sponsor of this Plan, unless the participant has been notified, in writing, that another entity is the Plan Sponsor. The Plan, any business associate servicing this Plan, or the Benefit Services Administrator cannot disclose protected health information to the Plan Sponsor unless the Plan Sponsor agrees to abide by the provisions outlined in this section.

The Plan Sponsor of this Plan has provided certification they agree to abide by these provisions.

PURPOSE OF DISCLOSURE TO PLAN SPONSOR

This Plan, any business associate servicing this Plan, or the Benefit Services Administrator will disclose protected health information to the Plan Sponsor only to permit the Plan Sponsor to administer the Plan consistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 Code of Federal Regulations Parts 160-64). Any disclosure to and use by this Plan Sponsor of protected health

- (g) will track disclosures it may make of protected health information so that it can

information will be subject to and must be consistent with the provisions outlined in the "Restrictions on Plan Sponsor's Use and Disclosure of Protected Health Information" and "Adequate Separation Between the Plan Sponsor and the Plan" sections that follow.

Neither this Plan, nor the Benefit Services Administrator, nor any business associate servicing this Plan will disclose protected health information to this Plan Sponsor unless the disclosures are explained in the Notice of Privacy Practices distributed to plan participants.

Neither this Plan, nor the Benefit Services Administrator, nor any business associate servicing the Plan will disclose protected health information to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

RESTRICTIONS ON PLAN SPONSOR'S USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Plan Sponsor:

- (a) will not use or further disclose protected health information, except as permitted or required by law;
- (b) will ensure that any agent, including any subcontractor, to whom it provides protected health information, agrees to the same restrictions and conditions that apply to the Plan Sponsor;
- (c) will not use or disclose protected health information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- (d) will report to the Plan, promptly upon the learning of, any use or disclosure of protected health information that is inconsistent with the uses and disclosures stated in the provisions outlined in this section ("Protected Health Information");
- (e) will make protected health information available to Plan participants in accordance with 45 CFR § 164.524;
- (f) will make protected health information available for amendment, and will, on notice, amend protected health information in accordance with 45 CFR § 164.526;

provide the information required by this Plan to account for disclosures in accordance with 45 CFR § 164.528; and

- (h) will make its internal practices, books, and records relating to its use and disclosure of protected health information available to the Plan, and to the U.S. Department of Health and Human Services to determine compliance with 45 CFR Parts 160-64.

When protected health information is no longer needed for the plan administrative functions for which the disclosure was made, the Plan Sponsor will, if feasible, return or destroy all protected health information, in whatever form or medium received from the Plan, including all copies of any data or compilations derived from and/or revealing member identity. If it is not feasible to return or destroy all of the protected health information, the Plan Sponsor will limit the use or disclosure of protected health information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

ADEQUATE SEPARATION BETWEEN THE PLAN SPONSOR AND THE PLAN

Certain individuals under the control of the Plan Sponsor may be given access to protected health information received from the Plan, a business associate servicing the group health plan, or the Benefit Services Administrator. This class of employees will be identified by the Plan Sponsor to the Plan and the Benefit Services Administrator from time to time as required under 45 Code of Federal Regulations §164.504. These individuals include all those who may receive protected health information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business.

These individuals will have access to protected health information only to perform the plan

administration functions that the Plan Sponsor provides for the Plan.

Individuals granted access to protected health information will be subject to disciplinary action and sanctions, including loss of employment or termination of affiliation with the Plan Sponsor, for any use or disclosure of protected health information in violation of or noncompliance with the provisions outlined in this section ("Protected Health Information"). The Plan Sponsor will promptly report such violation or noncompliance to the Plan, and will cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee causing the violation or noncompliance, and to mitigate any negative effect the violation or noncompliance may have on the member, the privacy of whose protected health information may have been compromised by the violation or noncompliance.

SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION

Title II of the Health Insurance Portability and Accountability Act of 1996 and the security regulations issued thereunder (collectively "HIPAA") requires Group Health Plans to secure participants' private health information that it creates, receives, maintains, or transmits electronically. This Plan will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic health information, and will require its agents and contractors to do the same. Reporting of known security incidents to the Plan is part of those safeguards.

This Plan has established safeguards that are supported by reasonable and appropriate security measures to ensure that the Plan does not disclose, or permit one of its agents or contractors to disclose, Protected Health Information to the entity adopting this Plan

**CITY OF URBANDALE
BENEFIT SUMMARY OPTION A
NON-UNION Closed Plan**

Effective Date: July 1, 2011

All benefits are subject to the following deductibles, coinsurance percentages and maximums unless otherwise stated.

MEDICAL BENEFITS	YOU PAY	GENERAL PLAN LIMITS	PAGE	
PPO OFFICE VISIT CO-PAY	\$5 Co-Pay then, Plan pays 100%	Deductible waived if \$5/visit Co-Pay charge applies. \$5/visit Co-Pay does not apply to out-of-pocket maximum. Co-Pays will continue even when the out-of-pocket maximum is met.	24	
Medical Deductible to be paid before the following benefits are paid: (per calendar year) - Per Individual - Per Family	\$100 \$200	Fourth quarter deductible carryover applies. Calendar year deductible waived if benefit requires a \$5/visit charge.	16	
Medical Out-of-Pocket Maximum amount you must pay: (per calendar year) - Per Individual - Per Family	\$500 \$1,000	This includes the calendar year deductible and coinsurance of 10% and 20%. The \$5 per visit charge for PPO physician visits does not accumulate to this maximum.	16	
Utilization Review: The Utilization Review program includes Preadmission Certification. Penalty for Non-Compliance: Preadmission Certification for all SelectFirst™ stays - the facility is responsible for obtaining pre-certification. Preadmission Certification for all other stays - the employee is responsible for obtaining pre-certification. Failure to comply with the Preadmission Certification provision will result in the benefit payment being reduced by 25% up to a maximum of \$300 for hospital-related inpatient charges. Pre-certification must take place prior to the admission or, in the case of an emergency admission, within two business days following the date of admission. Penalties will not apply to out-of-pocket maximums and deductible.			14	
MEDICAL BENEFITS	PPO PAYS	NON-PPO PAYS	GENERAL PLAN LIMITS	PAGE
Acupuncture	90%	80%	PPO and Non-PPO deductible applies.	24
Allergy - Exams Office - Injections Office Outpatient - Serums Office Outpatient - Testing Office Outpatient	\$5 Co-Pay 100% 100% 100% 100% 100% 100%	80% 80% 80% 80% 80% 80% 80%	PPO and Non-PPO deductible waived. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible waived.	24
Ambulance Benefits	90%	80%	Limited to local professional air or ground. PPO and Non-PPO deductible applies.	24
Ambulatory/Outpatient Surgical Facility	90%	80%	PPO and Non-PPO deductible applies.	19
Anesthesia - Office - Inpatient - Outpatient	\$5 Co-Pay 90% 90%	80% 80% 80%	PPO and Non-PPO deductible waived. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible applies.	24
Biofeedback - Office - Outpatient	\$5 Co-Pay 90%	80% 80%	PPO deductible waived. Non-PPO deductible applies. PPO and Non-PPO deductible applies.	24

OPTION A BENEFIT SUMMARY (Cont.)

MEDICAL BENEFITS	PPO PAYS	NON-PPO PAYS	GENERAL PLAN LIMITS	PAGE
Biologically Based Mental Illness - Office - Inpatient - Outpatient - Residential	\$5 Co-Pay 90% \$5 Co-Pay 90%	80% 80% 80% 80%	Includes autistic disorders. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible waived. Limited to inpatient treatment at a Psychiatric Medical Institution for Children (PMIC) for those who are under 21 and have been admitted by a physician. PPO and Non-PPO deductible applies.	24
Birthing Center Care	90%	80%	PPO and Non-PPO deductible applies.	19
Chemotherapy - Office visit only - Office services - Outpatient	\$5 Co-Pay 80% 80%	80% 80% 80%	PPO and Non-PPO deductible waived. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible applies.	25
Chiropractor	90%	80%	PPO and Non-PPO deductible applies.	24
Colorectal Screening Colonoscopy - Office - Outpatient Fecal Occult (routine) - Office - Outpatient Sigmoidoscopy (non-routine) - Office - Outpatient	 90% 90% 100% 100% \$5 Co-Pay 90%	 80% 80% 80% 80% 80% 80%	Under Age 50: Covered only if medically necessary. Age 50 and Older: Covered as routine: once every 10 years, covered if medically necessary. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible applies.	24
<p>NOTE: Benefits for preventive services may be available and payable at 100% if recommended by a physician and a PPO provider is used. Additional information is available online at the Federal Government Health Care Reform Site: http://www.healthcare.gov/law/provisions/preventive/index.html. If there is no coverage for a benefit through Health Care Reform, please see your current Plan for possible coverage.</p>				
Contraceptives Oral - Office Other - Office	 \$5 Co-Pay \$5 Co-Pay	 80% 80%	Includes coverage for prescription oral, injected, transdermal patches, and implanted contraceptives, as well as prescription contraceptive devices, such as IUD's and diaphragms. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible waived.	24
Dental Services Covered Under Medical - Office - Inpatient/Surgery - Outpatient	90% 100% 90%	80% 80% 80%	Includes covered charges by a dentist or dental surgeon for: 1. jaw and natural teeth repair if due to an accident and; 2. oral surgery consisting of cutting procedures for the treatment of diseases or extraction of impacted teeth as a hospital inpatient or outpatient. Excludes dental work or treatment unless caused by an accidental injury or extraction of impacted teeth services that qualify for coverage under this Plan. PPO and Non-PPO deductible applies.	22
Diabetic Self-Management Program	90%	80%	PPO and Non-PPO deductible applies.	24

OPTION A BENEFIT SUMMARY (Cont.)

MEDICAL BENEFITS	PPO PAYS	NON-PPO PAYS	GENERAL PLAN LIMITS	PAGE
Diagnostic X-ray, Lab Benefits, and other Diagnostic Services - X-ray Benefits - Physician's Office - Hospital/Outpatient - Independent Labs/X-rays - EKG, EEG, Stress Tests - Physician's Office - Hospital/Outpatient - Independent Labs/X-rays - MRI, MRA, CT Scans - Physician's Office - Hospital/Outpatient - Independent Labs/X-rays - Lab Benefits - Physician's Office - Hospital/Outpatient - Independent Labs/X-rays	\$5 Co-Pay 100% 100% \$5 Co-Pay 90% 90% \$5 Co-Pay 100% 100% 100% 90% 100%	80% 80% 80% 80% 80% 80% 80% 80% 80%	PPO and Non-PPO deductible waived. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible applies.	21, 25
Durable Medical Equipment	90%	80%	Rental limited to purchase price. Must be medically necessary. PPO and Non-PPO deductible applies.	24
Elective Surgical Sterilizations - Office - Inpatient - Outpatient	\$5 Co-Pay 100% 100%	80% 80% 80%	Excludes any surgery or other type of medical treatment performed on an elective, non-medically necessary basis unless otherwise specified as covered by this Plan. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible applies.	25
Emergency Room	90%	90%	PPO and Non-PPO deductible applies.	25
Home Health Care Services	90%	80%	PPO and Non-PPO deductible applies.	18
Hospice Care - Inpatient - Outpatient	90% 90%	80% 80%	Includes respite care. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible applies.	20
Hospital Benefits	90%	80%	PPO and Non-PPO deductible applies.	17
Mammogram (routine) - Office - Outpatient	100% 100%	80% 80%	As medically necessary or limited to: - one baseline mammogram between ages 35-39; - one mammogram every 2 years between ages 40-49; and - one mammogram annually ages 50 and over. PPO deductible waived. Non-PPO deductible applies. PPO deductible waived. Non-PPO deductible applies.	22, 25
<p>NOTE: Benefits for preventive services may be available and payable at 100% if recommended by a physician and a PPO provider is used. Additional information is available online at the Federal Government Health Care Reform Site: http://www.healthcare.gov/law/provisions/preventive/index.html. If there is no coverage for a benefit through Health Care Reform, please see your current Plan for possible coverage.</p>				
Maternity - Office Exam only Amniocentesis OB Labs OB Ultrasound - Inpatient Facility Physician - Outpatient - Newborn Care	\$5 Co-Pay 90% 100% 100% 90% 100% 90% 90%	80% 80% 80% 80% 80% 80% 80% 80%	Payable the same as any other illness. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible applies. PPO deductible waived. Non-PPO deductible applies. PPO deductible waived. Non-PPO deductible applies. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible applies. Paid as part of the mother's claim. PPO and Non-PPO deductible applies.	22

OPTION A BENEFIT SUMMARY (Cont.)

MEDICAL BENEFITS	PPO PAYS	NON-PPO PAYS	GENERAL PLAN LIMITS	PAGE
Mental/Nervous/Drug Abuse/Alcoholism				17
- Office	\$5 Co-Pay	80%	PPO and Non-PPO deductible waived.	
- Inpatient	90%	80%	PPO and Non-PPO deductible applies.	
- Outpatient	\$5 Co-Pay	80%	PPO and Non-PPO deductible waived.	
Developmental Delays			Includes ADHD and ADD.	24
- Office	\$5 Co-Pay	80%	PPO and Non-PPO deductible waived.	
- Outpatient	90%	80%	PPO and Non-PPO deductible applies.	
Morbid Obesity			Includes exams, prescription drugs, surgery, and diagnostic tests.	25
- Office	\$5 Co-Pay	80%	PPO and Non-PPO deductible waived.	
- Inpatient	100%	80%	PPO and Non-PPO deductible applies.	
- Outpatient	100%	80%	PPO and Non-PPO deductible applies.	
Nursing Facility	90%	80%	Confinement must begin within 14 days of a hospital confinement of at least 3 days. PPO and Non-PPO deductible applies. Private duty nursing is not a covered benefit.	18
Organ and/or Tissue Transplants	90%	80%	Covered human-to-human transplants include the following procedures: heart; heart/lung; single lung; double lung; liver; kidney/pancreas; cornea; kidney; pancreas; bone marrow (allogenic and/or autologous); stem cell and other transplant procedures which are considered non-experimental or non-investigational. Pre-certification required. PPO and Non-PPO deductible applies.	21
Physician				25
- Office/Clinic Visits	\$5 Co-Pay	80%	PPO and Non-PPO deductible waived.	
- Inpatient	100%	80%	PPO and Non-PPO deductible applies.	
- Outpatient	90%	80%	PPO and Non-PPO deductible applies.	
Preadmission Testing				17
- Office	100%	80%	PPO and Non-PPO deductible waived.	
- Outpatient	100%	80%	PPO and Non-PPO deductible applies.	
Preventive Care Services			Routine physicals examinations are covered.	22
Pap Smear (Routine)				
- Office	100%	80%	PPO and Non-PPO deductible waived.	
- Outpatient	100%	80%	PPO and Non-PPO deductible waived.	
Prostate				
- Office	100%	80%	PPO and Non-PPO deductible waived.	
- Outpatient	100%	80%	PPO and Non-PPO deductible waived.	
Immunizations				
- Office	100%	80%	PPO and Non-PPO deductible waived.	
- Outpatient	100%	80%	PPO and Non-PPO deductible waived.	
NOTE: Benefits for preventive services may be available and payable at 100% if recommended by a physician and a PPO provider is used. Additional information is available online at the Federal Government Health Care Reform Site: http://www.healthcare.gov/law/provisions/preventive/index.html . If there is no coverage for a benefit through Health Care Reform, please see your current Plan for possible coverage.				
Radiation Therapy				25
- Office	\$5 Co-Pay	80%	PPO and Non-PPO deductible waived.	
- Outpatient	100%	80%	PPO and Non-PPO deductible applies.	
Second Surgical Opinion Program (Voluntary)	100%	No coverage	PPO deductible waived.	20
Surgery				19
- Office	\$5 Co-Pay	80%	PPO and Non-PPO deductible waived.	
- Inpatient	100%	80%	PPO and Non-PPO deductible applies.	
- Outpatient	100%	80%	PPO and Non-PPO deductible applies.	

OPTION A BENEFIT SUMMARY (Cont.)

MEDICAL BENEFITS	PPO PAYS	NON-PPO PAYS	GENERAL PLAN LIMITS	PAGE
Therapies (Physical, Occupational, Speech) - Office - Outpatient	\$5 Co-Pay 100%	80% 80%	PPO and Non-PPO deductible waived. PPO and Non-PPO deductible applies.	25
Well-Baby and Well-Child Care	\$5 Co-Pay	80%	Includes immunizations, routine physical exam, related laboratory, x-rays and interpretation of x-rays and laboratory results. Limited to children up to age 7. PPO and Non-PPO deductible waived.	22
<p>NOTE: Benefits for preventive services may be available and payable at 100% if recommended by a physician and a PPO provider is used. Additional information is available online at the Federal Government Health Care Reform Site: http://www.healthcare.gov/law/provisions/preventive/index.html. If there is no coverage for a benefit through Health Care Reform, please see your current Plan for possible coverage.</p>				

OPTION A PRESCRIPTION DRUG PROGRAM BENEFITS

PRESCRIPTION DRUG BENEFITS	PATIENT'S LIABILITY	GENERAL PLAN LIMITS	PAGE
Retail		Limited to a 34-day supply for retail. Includes coverage for prescription oral, injected, transdermal patches, and implanted contraceptives, as well as prescription contraceptive devices, such as IUD's and diaphragms.	28
Generic	20%	Per prescription or refill.	
Brand	20%	Per prescription or refill.	
Oral Chemotherapy Drugs	20%	Per prescription or refill.	
Mail Order		Limited to a 90-day supply for mail order. Must use NPS (National Pharmaceutical Services) mail order.	28
Generic	20%	Per prescription or refill.	
Brand	20%	Per prescription or refill.	
Oral Chemotherapy Drugs	20%	Per prescription or refill.	
		The participant will pay 100% of the charge and will then be reimbursed by the Plan.	
		The medical deductible and out-of-pocket maximum will apply.	
		Additional benefits may be available for certain preventive drugs. Information is available online at the Federal Government Health Care Reform Site: http://www.healthcare.gov/law/provisions/preventive/index.html	

Pre-Existing Condition Exclusion Period: 90 days/12 months
Dependent Eligibility: 0/26
Coordination of Benefits: Standard; Birthday Rule

Notes:

- Newborn charges are paid under the mother's benefits.
- Well-baby and well-child charges are paid under the child's benefits. **Complete list of exclusions are found on page 26.**

**CITY OF URBANDALE
BENEFIT SUMMARY OPTION B
NON-UNION PLAN**

Effective Date: August 1, 2011

All benefits are subject to the following deductibles, coinsurance percentages and maximums unless otherwise stated.

MEDICAL BENEFITS	YOU PAY	GENERAL PLAN LIMITS	PAGE	
PPO OFFICE VISIT CO-PAY	\$15 Co-Pay then, Plan pays 100%	Deductible waived if \$15/visit Co-Pay charge applies. \$15/visit Co-Pay does not apply to out-of-pocket maximum. Co-Pays will continue even when the out-of-pocket is met.	24	
Medical Deductible to be paid before the following benefits are paid: (per calendar year) - Per Individual - Per Family Prosthetic Deductible (Limbs)	 \$500 \$1,000 \$135	Fourth quarter deductible carryover applies. Calendar year deductible waived if benefit requires a \$15/visit charge. Accumulates to the medical deductible.	16	
Medical Out-of-Pocket Maximum amount you must pay: (per calendar year) - Per Individual - Per Family	 \$1,000 \$2,000	This includes the calendar year deductible and coinsurance of 10% and 30%. The \$15 per visit charge for PPO physician visits and the prescription drug copayments do not accumulate to this maximum.	16	
Utilization Review: Penalty for Non-Compliance:	The Utilization Review program includes Preadmission Certification. Preadmission Certification for all SelectFirst™ stays - the facility is responsible for obtaining pre-certification. Preadmission Certification for all other stays - the employee is responsible for obtaining pre-certification. Failure to comply with the Preadmission Certification provision will result in the benefit payment being reduced by 25% up to a maximum of \$300 for hospital-related inpatient charges. Pre-certification must take place prior to the admission or, in the case of an emergency admission, within two (2) business days following the date of admission. Penalties will not apply to out-of-pocket maximums and deductible.		14	
MEDICAL BENEFITS	PPO PAYS	NON-PPO PAYS	GENERAL PLAN LIMITS	PAGE
Acupuncture	90%	70%	PPO and Non-PPO deductible applies.	24
Allergy - Exams Office - Injections Office Outpatient - Serums Office Outpatient - Testing Office Outpatient	 \$15 Co-Pay 100% 100% 100% 100% 100% 100%	 70% 70% 70% 70% 70% 70% 70%	PPO and Non-PPO deductible waived. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible waived.	24
Ambulance Benefits	90%	70%	Limited to local professional air or ground. PPO and Non-PPO deductible applies.	24
Ambulatory/Outpatient Surgical Facility	90%	70%	PPO and Non-PPO deductible applies.	19
Anesthesia - Office - Inpatient - Outpatient	 \$15 Co-Pay 90% 90%	 70% 70% 70%	PPO and Non-PPO deductible waived. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible applies.	24

OPTION B BENEFIT SUMMARY (Cont.)

MEDICAL BENEFITS	PPO PAYS	NON-PPO PAYS	GENERAL PLAN LIMITS	PAGE
Biofeedback - Office - Outpatient	\$15 Co-Pay 90%	70% 70%	PPO deductible waived. Non-PPO deductible applies. PPO and Non-PPO deductible applies.	24
Biologically Based Mental Illness - Office - Inpatient - Outpatient - Residential	\$15 Co-Pay 90% \$15 Co-Pay 90%	70% 70% 70% 70%	Includes autistic disorders. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible waived. Limited to inpatient treatment at a Psychiatric Medical Institution for Children (PMIC) for those who are under 21 and have been admitted by a physician. PPO and Non-PPO deductible applies.	24
Birthing Center Care	90%	70%	PPO and Non-PPO deductible applies.	19
Chemotherapy - Office visit only - Office services - Outpatient	\$15 Co-Pay 90% 90%	70% 70% 70%	PPO and Non-PPO deductible waived. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible applies.	25
Chiropractor	90%	70%	PPO and Non-PPO deductible applies.	24
Colorectal Screening Colonoscopy - Office - Outpatient Fecal Occult (routine) - Office - Outpatient Sigmoidoscopy (non-routine) - Office - Outpatient	 90% 90% 100% 100% \$15 Co-Pay 90%	 70% 70% 70% 70% 70% 70%	Under Age 50: Covered only if medically necessary. Age 50 and Older: Covered as routine: once every 10 years, covered if medically necessary. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible applies.	24
NOTE: Benefits for preventive services may be available and payable at 100% if recommended by a physician and a PPO provider is used. Additional information is available online at the Federal Government Health Care Reform Site: http://www.healthcare.gov/law/provisions/preventive/index.html . If there is no coverage for a benefit through Health Care Reform, please see your current Plan for possible coverage.				
Contraceptives Oral - Office Other - Office	 \$15 Co-Pay \$15 Co-Pay	 70% 70%	Includes coverage for prescription oral, injected, transdermal patches, and implanted contraceptives, as well as prescription contraceptive devices, such as IUD's and diaphragms. See the Rx coverage for oral contraceptive coverage. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible waived.	24
Dental Services Covered Under Medical - Office - Inpatient/Surgery - Outpatient	90% 100% 90%	70% 70% 70%	Includes covered charges by a dentist or dental surgeon for: 1. jaw and natural teeth repair if due to an accident and; 2. oral surgery consisting of cutting procedures for the treatment of diseases or extraction of impacted teeth as a hospital inpatient or outpatient. Excludes dental work or treatment unless caused by an accidental injury or extraction of impacted teeth services that qualify for coverage under this Plan. PPO and Non-PPO deductible applies.	22
Diabetic Self-Management Program	90%	70%	PPO and Non-PPO deductible applies.	24

OPTION B BENEFIT SUMMARY (Cont.)

MEDICAL BENEFITS	PPO PAYS	NON-PPO PAYS	GENERAL PLAN LIMITS	PAGE
Diagnostic X-ray, Lab Benefits, and other Diagnostic Services - X-ray Benefits - Physician's Office - Hospital/Outpatient - Independent Labs/X-rays - EKG, EEG, Stress Tests - Physician's Office - Hospital/Outpatient - Independent Labs/X-rays - MRI, MRA, CT Scans - Physician's Office - Hospital/Outpatient - Independent Labs/X-rays - Lab Benefits - Physician's Office - Hospital/Outpatient - Independent Labs/X-rays	\$15 Co-Pay 100% 100% \$15 Co-Pay 90% 90% \$15 Co-Pay 100% 100% 100% 90% 100%	70% 70% 70% 70% 70% 70% 70% 70% 70% 70% 70% 70%	PPO and Non-PPO deductible waived. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible applies.	21, 25
Durable Medical Equipment	90%	70%	Rental limited to purchase price. Must be medically necessary. PPO and Non-PPO deductible applies.	24
Elective Surgical Sterilizations - Office - Inpatient - Outpatient	\$15 Co-Pay 100% 100%	70% 70% 70%	Excludes any surgery or other type of medical treatment performed on an elective, non-medically necessary basis unless otherwise specified as covered by this Plan. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible applies.	25
Emergency Room	90%	90%	PPO and Non-PPO deductible applies.	25
Home Health Care Services	90%	70%	PPO and Non-PPO deductible applies.	18
Hospice Care - Inpatient - Outpatient	90% 90%	70% 70%	Includes respite care. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible applies.	20
Hospital Benefits	90%	70%	PPO and Non-PPO deductible applies.	17
Mammogram (routine) - Office - Outpatient	100% 100%	70% 70%	As medically necessary or limited to: - one baseline mammogram between ages 35-39; - one mammogram every 2 years between ages 40-49; and - one mammogram annually ages 50 and over. PPO deductible waived. Non-PPO deductible applies. PPO deductible waived. Non-PPO deductible applies.	22, 25
<p>NOTE: Benefits for preventive services may be available and payable at 100% if recommended by a physician and a PPO provider is used. Additional information is available online at the Federal Government Health Care Reform Site: http://www.healthcare.gov/law/provisions/preventive/index.html. If there is no coverage for a benefit through Health Care Reform, please see your current Plan for possible coverage.</p>				

OPTION B BENEFIT SUMMARY (Cont.)

MEDICAL BENEFITS	PPO PAYS	NON-PPO PAYS	GENERAL PLAN LIMITS	PAGE
Maternity - Office Exam only Amniocentesis OB Labs OB Ultrasound - Inpatient Facility Physician - Outpatient - Newborn Care	 \$15 Co-Pay 90% 100% 100% 90% 100% 90% 90%	 70% 70% 70% 70% 70% 70% 70% 70%	Payable the same as any other illness. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible applies. PPO Deductible waived. Non-PPO deductible applies. PPO Deductible waived. Non-PPO deductible applies. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible applies. Paid as part of the mother's claim. PPO and Non-PPO deductible applies.	22
Mental/Nervous/Drug Abuse/Alcoholism - Office - Inpatient - Outpatient Developmental Delays - Office - Outpatient	 \$15 Co-Pay 90% \$15 Co-Pay \$15 Co-Pay 90%	 70% 70% 70% 70% 70%	 PPO and Non-PPO deductible waived. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible waived. Includes ADHD and ADD. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible applies.	17
Morbid Obesity - Office - Inpatient - Outpatient	 \$15 Co-Pay 100% 100%	 70% 70% 70%	Includes exams, prescription drugs, surgery, and diagnostic tests. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible applies.	25
Nursing Facility	90%	70%	Confinement must begin within 14 days of a hospital confinement of at least three days. PPO and Non-PPO deductible applies. Private duty nursing is not a covered benefit.	18
Organ and/or Tissue Transplants	90%	70%	Covered human-to-human transplants include the following procedures: heart; heart/lung; single lung; double lung; liver; kidney/pancreas; cornea; kidney; pancreas; bone marrow (allogenic and/or autologous); stem cell and other transplant procedures which are considered non-experimental or non-investigational. Pre-certification required. PPO and Non-PPO deductible applies.	21
Physician - Office/Clinic Visits - Inpatient - Outpatient	 \$15 Co-Pay 100% 90%	 70% 70% 70%	PPO and Non-PPO deductible waived. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible applies.	25
Preadmission Testing - Office - Outpatient	 100% 100%	 70% 70%	PPO and Non-PPO deductible waived. PPO and Non-PPO deductible applies.	21
Preventive Care Services Pap Smear (Routine) - Office - Outpatient Prostate - Office - Outpatient Immunizations - Office - Outpatient	 100% 100% 100% 100% 100% 100%	 70% 70% 70% 70% 70% 70%	Routine physicals examinations are covered. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible waived. PPO and Non-PPO deductible waived.	22
<p>NOTE: Benefits for preventive services may be available and payable at 100% if recommended by a physician and a PPO provider is used. Additional information is available online at the Federal Government Health Care Reform Site: http://www.healthcare.gov/law/provisions/preventive/index.html. If there is no coverage for a benefit through Health Care Reform, please see your current Plan for possible coverage.</p>				

OPTION B BENEFIT SUMMARY (Cont.)

MEDICAL BENEFITS	PPO PAYS	NON-PPO PAYS	GENERAL PLAN LIMITS	PAGE
Radiation Therapy - Office - Outpatient	\$15 Co-Pay 100%	70% 70%	PPO and Non-PPO deductible waived. PPO and Non-PPO deductible applies.	25
Second Surgical Opinion Program (Voluntary)	100%	No Coverage	PPO deductible waived.	20
Surgery - Office - Inpatient - Outpatient	\$15 Co-Pay 100% 100%	70% 70% 70%	PPO and Non-PPO deductible waived. PPO and Non-PPO deductible applies. PPO and Non-PPO deductible applies.	19
Therapies (Physical, Occupational, Speech) - Office - Outpatient	\$15 Co-Pay 100%	70% 70%	PPO and Non-PPO deductible waived. PPO and Non-PPO deductible applies.	25
Well-Baby and Well-Child Care	\$15 Co-Pay	70%	Includes immunizations, routine physical exam, related laboratory, x-rays and interpretation of x-rays and laboratory results. Limited to children up to age 7. PPO and Non-PPO deductible waived.	22
<p>NOTE: Benefits for preventive services may be available and payable at 100% if recommended by a physician and a PPO provider is used. Additional information is available online at the Federal Government Health Care Reform Site: http://www.healthcare.gov/law/provisions/preventive/index.html. If there is no coverage for a benefit through Health Care Reform, please see your current Plan for possible coverage.</p>				

OPTION B PRESCRIPTION DRUG PROGRAM BENEFITS

PRESCRIPTION DRUG BENEFITS	PATIENT'S LIABILITY	GENERAL PLAN LIMITS	PAGE
Retail		Limited to a 34-day supply or 100 units; whichever is less for retail. Includes coverage for prescription oral, injected, transdermal patches, and implanted contraceptives, as well as prescription contraceptive devices, such as IUD's and diaphragms.	28
Generic Preferred Brand Non Preferred Brand Oral Chemotherapy Drugs	\$10 Co-Pay \$25 Co-Pay \$40 Co-Pay 10% Co-Pay	Per prescription or refill. Per prescription or refill. Per prescription or refill. Per prescription or refill. Medical deductible and out-of-pocket maximum will apply.	
Mail Order		Limited to a 90-day supply for mail order. Must use NPS (National Pharmaceutical Services) mail order.	28
Generic Preferred Brand Non Preferred Brand Oral Chemotherapy Drugs	\$25 Co-Pay \$65 Co-Pay \$100 Co-Pay 10% Co-Pay	Per prescription or refill. Per prescription or refill. Per prescription or refill. Per prescription or refill. Medical deductible and out-of-pocket maximum will apply.	
<p>Additional benefits may be available for certain preventive drugs. Information is available online at the Federal Government Health Care Reform Site: http://www.healthcare.gov/law/provisions/preventive/index.html</p>			

Pre-Existing Condition Exclusion Period: 90 days/12 months
Dependent Eligibility: 0/26
Coordination of Benefits: Standard; Birthday Rule

Notes:

- Newborn charges are paid under the mother's benefits.
- Well-baby and well-child charges are paid under the child's benefits. **Complete list of exclusions are found on page 26.**

BENEFIT MANAGEMENT PROVISIONS

To ensure that cost-effective services are provided, the utilization review company places responsibility for benefit management with physicians, as they control health care utilization. When benefit management procedures are not followed, the result will be a reduction in payment to contracting providers for which the patient is not liable.

PRIOR APPROVAL

Prior approval is required prior to the participant receiving certain services, supplies, or procedures. The participant or the health care provider must request prior approval from the Benefit Services Administrator. Prior approval determines whether a proposed treatment plan is an eligible expense under the Plan. Without prior approval for certain services, a proposed treatment plan may not be a covered benefit. Services that require prior approval include:

- *Organ and/or Tissue Transplants*
- *Morbid Obesity*
- *Hospice Care*

If the participant's request is approved, he or she knows his or her Plan covers the specific services or procedures. If benefits are denied, the participant will receive written notice in which the reason(s) for denial will be listed. The notice will be mailed to the most current address the Plan Administrator has on record for the participant and his or her health care provider. **If the participant does not request prior approval, the service may not be covered.**

Certain factors may alter or impact whether the participant receives approval. These factors include benefit limitations, continued Plan participation, and the date he or she receives services.

UTILIZATION REVIEW

The utilization review program reviews the medical necessity of hospital inpatient and nursing facility admissions for all medical, surgical, mental health, chemical dependency and rehabilitation admissions. The utilization review provisions do not apply when Medicare is the primary payer.

When the participant receives care from a SelectFirstTM provider, the provider will handle the preadmission certification. If a penalty for failure to comply is involved, the participant is not responsible. However, if the participant seeks care from a non-SelectFirstTM provider, the participant is then responsible for compliance with the utilization review provisions as described in the following sections. Any penalties incurred will be the participant's responsibility.

The utilization review unit is staffed with registered, licensed nurses with at least five years of medical/surgical or mental health/chemical dependency experience.

Their phone lines are available 24-hours per day, every day of the year. The utilization review coordinator can be reached at:

Nationwide 1-800-782-9955

If services are determined to be not medically necessary or not covered by this Plan, benefits will be denied.

Important Note: If the participant disagrees with a reduction in or denial of benefits, please see the Claims Review Procedure sections for information on how to file an appeal. These sections also outline the time frames in which the Plan must respond to the claim and/or appeal.

Preadmission Certification

SelectFirstTM Providers

All scheduled inpatient admissions for SelectFirstTM participants must be pre-certified by SelectFirstTM before hospitalization occurs. It is the SelectFirstTM physician's responsibility to obtain this preadmission certification for all scheduled hospitalizations.

Non-SelectFirstTM Providers

If a participant obtains services from a non-SelectFirstTM hospital, it is the responsibility of the patient to pre-certify the hospital admission. **The participant** will be responsible for any penalty for failure to pre-certify.

Each hospital, rehabilitation or nursing facility stay, planned or unplanned, requires preadmission certification. Preadmission certification includes physician review, continued stay review, and discharge planning.

Planned inpatient stays must be reported to the utilization review unit prior to the actual admission. Unplanned/Urgent Care admissions

must be reported **within two business days** following the date of admission. **Please note:** Observation exceeding 23 hours will be considered an inpatient admission and must be reviewed. See the Preadmission Certification criteria contained in the Benefit Management Provisions section of this Plan for proper direction in obtaining Utilization Review.

If the participant fails to comply with any part of the preadmission certification provision, the total hospital bill will be reduced by 25% up to a maximum of \$300, and then paid at the normal benefit allowance. This reduction in benefits will not apply to the participant's out-of-pocket maximums.

A request for pre-certification will be accepted from anyone familiar with the patient, but ultimate responsibility remains the patient's. In most cases certification is given during the initial conversation. If, for some reason, an inpatient stay does not meet the criteria, the nurse reviewer will consult with a physician reviewer and respond to the appropriate parties.

Physician Review

Nurse reviewers certify the majority of inpatient stays, but if the participant's condition or treatment plan does not satisfy certain criteria, consultation begins with a physician reviewer. The selection of a physician reviewer depends on the patient's diagnosis and the procedures that have been or will be involved in the course of treatment. The physician selected will represent a medical specialty which is directly related to the patient's condition.

The attending physicians' name(s) will be shared with the physician reviewer after a decision is made. Then the attending physician is encouraged to talk with the physician reviewer about any questions or concerns regarding the decision.

In the event of a denial or reduction of benefits, the participant (or his/her authorized representative), the attending physician and the hospital are notified immediately. Such a decision can be appealed within 180 days. In this case, First Administrators, Inc. will contact other physicians to review the admission. If any of these physicians decides to approve benefits, the decision will be reversed.

Continued Stay Review

The utilization review staff does not assign lengths of stay when an inpatient stay is certified. Each admission is closely monitored to verify that services being provided remain

medically necessary. This review begins on the second day of a hospital stay. Physician reviewers are consulted whenever services being provided or requested do not meet medical necessity standards.

Discharge Planning

Discharge planning begins the day of admission. The purpose of this provision is to ensure maximum coordination among the family, health care provider and utilization review staff in the event discharge to alternative care is warranted. Every effort is made throughout each stay to maintain patient care in the most cost-effective setting while not sacrificing the quality of care.

Any penalty will be waived for maternity stays with duration of 48 hours for a normal vaginal delivery, or 96 hours for a cesarean section. Penalties may be applied to maternity stays which exceed these guidelines.

External Review

If the appeal process has been exhausted regarding a denial of benefits based on medical necessity, the participant or his/her provider, acting on his/her behalf, may be entitled to request an external review of the Plan Administrator's decision through the Iowa Commissioner of Insurance. Requests must be filed in writing at the following address, no later than 60 days following the Plan Administrator's decision.

Iowa Division of Insurance
330 Maple Street
Des Moines, Iowa 50319-0065
Fax: 1-515-281-3059
Telephone: 1-515-281-5705

HOW PREFERRED PROVIDER ORGANIZATIONS (PPO) WORK

PAYMENT METHOD

Contracts between the Plan and the PPO provide that all services performed within the PPO area are subject to a fee schedule. Eligible expenses for services provided by non-PPO providers are limited to the lesser of the actual amount charged for the services or the maximum allowable fee. You are responsible for the difference between the amount charged and the allowable expense if you choose to obtain services from a non-PPO provider. Allowable expenses is the portion of an eligible expense actually payable by this Plan, after taking into account co-pay, deductible, and coinsurance amounts, any applicable benefit maximum or maximums, and any other limitation or exclusion provided for under this Plan.

DESCRIPTION OF MEDICAL BENEFITS

HOW THE MEDICAL PLAN WORKS

Individual Deductible

Each participant, unless otherwise specified, will be responsible for the individual calendar year deductible amount specified in the benefit summary before any medical benefits will be paid by this Plan.

Family Deductible

If the employee elects to take family coverage, the total deductible the employee and his/her covered dependents will have to pay in a calendar year will never be more than the family deductible amount specified in the benefit summary. Each participant's responsibility will be limited to the individual deductible amount specified in the benefit summary. The family deductible is the same no matter how many dependents he/she may have.

PPO Office Visit Co-Pay

An office visit co-pay will apply once per day per physician. This office visit co-pay does not apply to the calendar year deductible or the out-of-pocket maximum described below.

Deductible Carryover

Eligible expenses incurred during October, November, and December which were applied toward that year's deductible will also be applied toward the next year's deductible.

Coinsurance

Once the calendar year deductible has been paid, this Plan will pay the coinsurance percentages of the covered medical expenses outlined in the benefit summary.

Out-of-Pocket Maximum

There are limits on how much the employee will have to pay per individual, or per family, in allowable medical expenses per calendar year. The benefit summary specifies what the out-of-pocket maximum includes and what it excludes. The out-of-pocket maximum never includes ineligible charges. Once the out-of-pocket maximum has been met, this Plan pays 100% of the allowable expenses.

WHAT ARE COVERED MEDICAL BENEFITS?

All services must be medically necessary. The Benefit Services Administrator determines what is medically necessary, however, if necessary, the Plan Administrator makes the final determination whether a service is medically necessary, and that decision is final and conclusive. This Plan may include benefits not normally considered medically necessary. These are specifically included as benefits on the following pages.

The fact that a physician or dentist may have prescribed, ordered, recommended, or approved the provision of certain services or supplies does not necessarily mean such services or supplies are medically necessary or make the service a covered expense.

Following is a summary of allowable expenses under this Plan. If you receive services within the PPO area, eligible expenses for those services are limited to the lesser of the actual amount charged or the amount provided by the fee schedule. If you receive services from non-PPO providers, eligible expenses for those services are limited to the lesser of the actual amount charged or the maximum allowable fee.

HOSPITAL BENEFITS

Hospital benefits include the daily room and board charge for each day of confinement up to the semi-private room rate for the level of care the patient is receiving. If the hospital does not have semi-private rooms, benefits will be paid at the lowest private room rate. Charges for special care units, (e.g., isolation or intensive care rooms and operating rooms), are covered provided level of care was prescribed by a physician and deemed to be medically necessary. Payment will be made for the hospital's miscellaneous covered charges incurred during a period of confinement for which room and board benefits are payable. Miscellaneous covered hospital charges include anesthetics and their administration, if provided by the hospital or its staff.

Personal convenience items including, but not limited to, televisions, telephones, and admission kits are not payable expenses under this Plan.

IN-HOSPITAL PHYSICIAN BENEFITS

In-hospital services by a physician for professional treatment of an illness or injury are covered benefits of this Plan. Only one visit per day will be considered an eligible expense, unless additional visits are deemed to be medically necessary.

This benefit includes consultations by other physicians providing it is medically necessary and recommended by the attending physician. The consulting physician must be conferring in a medical specialty different than the specialty of the attending physician or any other consulting physician.

MENTAL/NERVOUS/DRUG ABUSE/ALCOHOLISM BENEFITS

This Plan provides benefits for the following mental/nervous and drug abuse/alcoholism related services.

Inpatient Hospital Benefits

Hospital benefits include daily room and board charges up to the semi private room rate for the level of care the patient is receiving. This Plan will provide benefits for hospital miscellaneous covered charges such as therapy and supplies incurred during the time room and board benefits are payable.

Hospital Outpatient and Physician Office Benefits

Unless otherwise excluded, this Plan will provide benefits for medically necessary services including partial hospitalization and therapy and supplies provided in an outpatient or office setting. Covered charges for professional fees will include only those of a physician legally licensed to practice medicine and surgery.

Chemical Dependency Facility Benefits

Chemical Dependency Facility Care provides treatment for alcohol or drug abuse disorders. This benefit will pay for the daily room and board charges and miscellaneous charges such as therapy and supplies.

Confinement in a chemical dependency facility must be recommended by a physician and under the supervision of a physician.

Psychiatric Medical Institution for Children (PMIC) Residential Facility Benefits

This Plan will provide benefits for the daily room and board charges subject to the limits of this Plan. Also included is coverage for miscellaneous charges such as therapy and supplies incurred during the time room and board benefits are payable. Confinement in a PMIC residential treatment facility, for participants under age 21, must be recommended by and under the supervision of a physician. When a participant, under age 21 has received services in a PMIC facility services must be completed before the earlier of the following:

- a) The date the participant no longer requires services; or
- b) The date the participant reaches age 22.

NURSING FACILITY BENEFITS

Benefits are provided for nursing facility medical care and are a covered benefit providing such care is medically necessary to treat an illness or injury and is prescribed by a physician. Nursing facilities are used by those who require rehabilitation or additional time to recover from an illness or injury, but do not need the acute care provided in a hospital.

Confinement in a nursing facility must begin within 14 days of a hospital confinement of at least three consecutive days.

A nursing facility is:

- an institution that furnishes room and board and skilled nursing services for medical care;
- has one or more licensed nurses on duty at all times under the supervision, on a 24-hour basis, of a registered nurse (RN) or a physician;
- has available at all times under an established agreement the services of such a physician;
- complies with the legal requirements applicable to such an institution, and
- maintains daily medical records on all patients.

The following is not a nursing facility:

- any institution or part thereof used principally as a rest facility, or a facility for the aged, drug addict, alcoholic, or

for providing custodial or educational care.

Payable charges for services include room and board (including general nursing care), special treatment rooms, x-ray and laboratory examinations, physical, occupational or speech therapy, oxygen and other gas therapy and any other services customarily provided by a nursing facility. Room and board charges are limited to the semi-private room rate for the level of care the patient is receiving.

Nursing facility benefits do not include services in connection with a mental/nervous or drug abuse/alcoholism disorder.

HOME HEALTH CARE SERVICES

Home health care benefits consist of the following medically necessary services for the treatment of an injury or illness when prescribed by a physician:

- part-time nursing care provided in the covered person's home by a registered nurse (RN), a licensed practical nurse (LPN), or a licensed public health nurse (LPHN);
- part-time or intermittent home care by a home health aide;
- physical, occupational, or speech therapy, provided in the participant's home;
- physical, occupational or speech therapy, or the use of medical appliances or equipment provided on an outpatient basis by a home health agency, or by a hospital or other facility under an arrangement with a home health agency;
- medical supplies, drugs, and medications prescribed by a physician; and
- laboratory services by or on behalf of a hospital.

Home health care benefits will not include:

- any services performed by a member of the covered person's immediate family or a person ordinarily residing in the participant's home;
- any services not necessary for the treatment of an injury or illness;
- meals, personal convenience items, or housekeeping services. These health services are not payable if the patient

has a mental illness or functional disorder of any type, or alcoholic disorder, or disorder caused by drug abuse;

- services where the entire period of home services, including all charges, was not certified as medically necessary by the patient's attending physician.

SURGICAL BENEFITS

Surgical benefits include professional fees for performing a covered surgical procedure to treat an illness or injury. Services may be provided on an inpatient or outpatient basis at a hospital or in a physician's office. Surgical benefits include the following:

- the operative and cutting procedures for treatment of fractures or dislocations, and suturing of wounds;
- hospital, surgery, and anesthesia charges for certain individuals who need dental care provided on an inpatient setting. These individuals include: children under the age of five when it is determined that the dental care cannot be provided in a dentist's office. It also includes other individuals who have a medical condition that would create significant or undue risk for the individual if care was not provided in a hospital or ambulatory surgical center;
- surgical assistance services in the performance of a surgical procedure if the assistant is not an intern, resident or member of the hospital's staff or compensated by the hospital and the type of procedure and condition of the patient requires the assistance. Surgical assistance charges are limited to 20% of the eligible expense for that surgical procedure;
- administration of anesthesia in connection with a surgical procedure, if the anesthetic is administered by a physician or certified registered nurse anesthetist (CRNA), other than the operating or assistant surgeon, and the physician is not employed or compensated by the institution-hospital in which the surgery is performed and the physician bills for the administration of anesthetics.

Compensation for usual pre-operative and post-operative care is included in the payment for surgical services.

Benefits for multiple surgical procedures will be considered at 100% of the eligible expense for the primary procedure and 50% of the eligible expense for any secondary procedures.

Benefits for two like surgical procedures (i.e., bilateral procedures) will be considered at 150% of the eligible expense for the procedure.

This Plan is in compliance with the Women's Health and Cancer Rights Act of 1998 and, for individuals who choose breast reconstruction surgery, the Plan will allow benefits for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

SelectFirst™ Physicians

The participant is not responsible for any charges above the contractual allowance for the surgery.

Non-SelectFirst™ Physicians in the SelectFirst™ Area

The participant is responsible for the difference between the billed amount and the paid amount.

Non-PPO Physicians

Charges are subject to the calendar year deductible and the maximum allowable fee limits.

AMBULATORY/OUTPATIENT SURGERY FACILITY BENEFITS

This benefit includes coverage for the facility charges of an "ambulatory surgery center." An ambulatory surgery center is any public or private establishment with an organized medical staff of physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing outpatient surgical procedures, with continuous physician services and registered professional nursing services whenever a patient is in the facility, and which does not provide services or other accommodations for patients to stay overnight.

BIRTHING CENTER CARE BENEFITS

Birthing centers provide care for pregnant women through the services of a nurse midwife. A nurse midwife provides obstetric services with an obstetrician on 24-hour medical back-up in case of complications. The mother and baby are usually discharged from the center within 10-12 hours after birth with home follow-up visits provided. Services may vary from center to center.

Covered services include the room and board charges and eligible expenses for any necessary services and supplies while confined. Benefits are limited to expenses incurred while confined for a period of time not to exceed 24 hours. Expenses incurred beyond the initial 24-hour period may be covered expenses under other benefits of this Plan.

SECOND SURGICAL OPINION PROGRAM (VOLUNTARY)

The Second Surgical Opinion Program is included under this Plan. This program provides additional information before a participant decides to have an elective surgery. This information may be valuable to in helping the participant decide whether to use alternative treatment for his/her medical condition. The program allows the individual to obtain an additional medical regarding treatment of the condition. The advice is provided at no cost to the participant—it is a fully-paid benefit of this Plan.

The program applies to all individuals covered by this Plan. This includes the employee, spouse and child(ren) if each is covered by the Plan. Each covered person may seek a second surgical opinion when he/she has a medical condition for which a surgeon has recommended an elective surgical procedure.

To ensure the participant is comfortable with that opinion, advice from a third physician may be sought in certain medical circumstances. These opinions should be obtained from a physician who is not financially or professionally associated with the participant's physician. If the physician is unable to recommend such a specialist, First Administrators, Inc. should be contacted for the name and address of one in, or near, the participant's area.

If possible, the specialist performing the second opinion should use the same test results as the participant's physician used. Duplicate labs or x-rays taken by both physicians are not medically

necessary. The participant should bring copies of his/her physician's test results to be reviewed during the secondary opinion.

This Plan suggests a participant obtain a second opinion for the following surgeries:

Surgery List

- Back Surgery
- Breast Surgery
- Bunion Surgery
- Cataract Surgery
- Foot Surgery
- Gallbladder Surgery
- Hemorrhoid Surgery
- Hernia Repair
- Hip Surgery
- Hysterectomy
- Knee Surgery
- Nasal Surgery
- Prostate Surgery
- Tonsillectomy,
- Adenoidectomy
- Varicose Vein Surgery
- Wrist Surgery

The final decision on whether or not to have surgery is the participant's. While the intent is not to limit access to medical care, this Plan wants the participant to be informed and comfortable with his/her decision to have surgery.

HOSPICE CARE BENEFITS

Hospice services are those which help terminally ill participants and their families continue life with minimal disruption of normal activities.

The decisions relating to patient care are shared by an interdisciplinary hospice care team. The team is responsible for assuring continuity of care and providing professional management of all services. The attending physician is considered a member of this team. The attending physician updates, reviews, and approves the care plan as often as appropriate to meet the changing needs of the hospice patient and his/her family. The physician remains the primary provider of medical care.

Services reimbursed by this Plan for hospice care must be necessary for the palliation or management of the terminal illness and related conditions. Services covered must be consistent with the plan of care of the hospice care team. All services must be prescribed by and under the supervision of the attending physician and approval from the Benefit Services Administrator must be obtained prior to commencement of hospice care.

The following types of hospice expenses are covered by this Plan:

- room and board in a hospice facility, hospital (up to the semi-private room rate for the level of care provided) or nursing

facility (up to the semi-private room rate for the level of care provided);

- part-time or intermittent nursing care by a registered nurse (RN) or licensed practical nurse (LPN) for up to eight hours in any one day;
- other necessary services such as medical supplies, medicines, drugs, physician's services and the rental or purchase of durable medical equipment;
- psychological and dietary counseling;
- physical and occupational therapy;
- part-time or intermittent home health aide services consisting mainly of caring for the individual for up to eight hours in any one day;
- assessment of the individual's social, emotional and medical needs, and the home and family situation; and
- respite care which is furnished during a period of time when the participant's family or usual caretaker cannot, or will not, attend to the participant's needs.

Some items **not** covered under hospice care are:

- bereavement counseling;
- funeral arrangement;
- pastoral counseling;
- financial or legal counseling which includes estate planning or the drafting of a will;
- homemaker or caretaker services which are not solely related to care of the participant, including sitter or companion services for either the participant who is ill or other members of the family;
- transportation; and
- house cleaning and maintenance of the house.

ORGAN AND/OR TISSUE TRANSPLANT BENEFITS

Benefits are payable for participant charges of transplant services. Pre-certification must be obtained prior to beginning any transplant services.

Covered human-to-human transplants include the following procedures: heart; heart/lung; single lung; double lung; liver; kidney/pancreas;

cornea; kidney; pancreas; bone marrow (allogenic and/or autologous); stem cell and other transplant procedures which are considered non-experimental or non-investigational.

When both the recipient and donor are covered by this Plan, services will be covered for each patient. If only the recipient is covered by this Plan, services will only be covered for the recipient. Donor charges are not covered. If the donor is covered under this Plan but the recipient is not covered, no expenses will be covered for either the recipient or the donor.

Some items **not** covered under transplant benefits are:

- any charges incurred for procurement or delivery of any organ;
- lodging and meals;
- any charges incurred by the donor of an organ or tissue unless otherwise specified by this Plan;
- any services or supplies related to transplants involving mechanical organs; and
- expenses associated with the purchase of any organ or tissue.

OUTPATIENT X-RAY AND LABORATORY BENEFITS

Outpatient x-ray and laboratory services in connection with the diagnosis and treatment of an illness or injury are covered benefits of this Plan. These services must be recommended by a physician. They may be performed in a physician's office, the outpatient department of a hospital, or in a free-standing diagnostic lab and x-ray center.

PREADMISSION TESTING

Diagnostic x-ray and laboratory services in connection with a scheduled hospital admission for the treatment of illness or injury are covered benefits of this Plan. These services must be made and recommended by a physician.

Many people find this benefit most useful prior to a scheduled hospitalization. This allows the participant to reduce the length of his/her hospital stay by having many of the tests performed a day or two prior to admission. Additionally, the participant may elect to be discharged earlier and return for follow-up tests at a later date, also on an outpatient basis.

MATERNITY BENEFITS

Expenses incurred by all female participants of this Plan as the result of pregnancy will be covered in the same manner as services for any other illness. Benefits will be paid according to the Plan provision for the type of expense incurred, i.e., hospital expenses under the hospital expense benefit, obstetrical delivery under the surgical expense benefit, etc.

This Plan is in compliance with The Newborns' and Mothers' Health Protection Act of 1996. This act specifies that if plans provide maternity benefits for mothers and newborns, those benefits must include a minimum 48-hour hospital confinement following a vaginal delivery or a minimum 96-hour hospital confinement following a cesarean delivery. Earlier discharges are permitted if the attending physician and the mother agree to an earlier discharge. Penalties cannot be applied if inpatient maternity stays that are within these time frames are not pre-certified. However, penalties may be applied to maternity stays that exceed these timeframes, if not pre-certified.

Inpatient Newborn Benefits

Expenses incurred for care of a newborn, including routine nursery room and board, routine inpatient physician visits and circumcision will be considered part of the mother's maternity expenses and will be paid as part of her claim until the newborn is discharged from the hospital.

DENTAL SERVICES COVERED UNDER MEDICAL BENEFITS

The following services, including those services billed by a dentist or dental surgeon, are covered under this Plan;

- jaw and natural teeth repair if due to an accidental injury (excludes treatment for injuries associated with the act of mastication);
- the correction of congenital abnormalities of the jaw;
- reduction of fractures of the facial bones;
- excision of the mandibular joints;
- excision of lesions;
- incision of accessory sinus, mouth, salivary glands, or ducts;

- plastic reconstruction or repair of the mouth or lips to correct defects due to an accidental injury; and/or
- surgical removal of impacted teeth as an inpatient or outpatient (includes outpatient hospital or dentist's office).

If a participant also has dental coverage then that Plan would be primary and this Plan would be secondary for the above procedures.

PREVENTIVE CARE SERVICES

This Plan has been designed to encourage each participant to promote good health by providing benefits for certain preventive care.

Routine x-ray and laboratory services as part of a routine exam will be considered under preventive care services. This includes routine pap smears, prostate screening, and mammograms.

Please refer to the benefit summary for a complete list of covered expenses and the limitations applicable to each benefit.

Benefits mandated through the Federal Government's ACA legislation include preventive care such as immunizations, screenings, and other services that are listed as recommended by the *United States Preventive Services Task Force (USPSTF)*, the *Health Resources Services Administration (HRSA)*, and the *Federal Centers for Disease Control (CDC)*.

See

<http://www.healthcare.gov/law/provisions/preventive/index.html> for more details.

Important Note: The preventive care services identified through this link are *recommended services*, not mandated services. It is up to the provider of care to determine which services to provide.

WELL-BABY AND WELL-CHILD CARE

This Plan provides routine well-child care including immunizations, routine physical exam, related laboratory, x-rays and interpretation of x-rays and laboratory results.

Routine well-child care is covered up to age 7, at approximately the following age intervals: 3 years, 4 years, 5 years, and 6 years.

Immunizations, when provided at approximately the following age intervals: birth, 2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, and 24 months.

The deductible is waived for routine well-baby care, routine well-child care, and immunizations.

Benefits mandated through the Federal Government's ACA legislation include preventive care such as immunizations, screenings, and other services that are listed as recommended by the *United States Preventive Services Task Force (USPSTF)*, the *Health Resources Services Administration (HRSA)*, and the *Federal Centers for Disease Control (CDC)*.

See <http://www.healthcare.gov/law/provisions/preventive/index.html> for more details.

Important Note: The preventive care services identified through this link are *recommended services*, not mandated services. It is up to the provider of care to determine which services to provide.

OTHER COVERED MEDICAL CARE

The following are covered benefits providing such care is medically necessary to treat an illness or injury:

1. **acupuncture**;
2. **allergy tests, serum, exams, and injections**;
3. charges for local professional air or ground **ambulance service**;
4. **anesthesia** and administration;
5. **biofeedback** for medical and psychological diagnoses if medically necessary and performed by a qualified practitioner;
6. **biologically based** mental illness as defined in this Plan and includes autistic disorders;
7. **blood**, blood plasma, and blood plasma expanders, and their administration, when not available without charge (i.e. blood bank);
8. manual, mechanical manipulation of the spinal column (**chiropractic** benefits);
9. **colorectal screening** under age 50 covered only if medically necessary and over age 50 covered as routine once every 10 years or if medically necessary;
10. physician or surgeon services for a surgical procedure and other medical care, including charges made by a physician for **consultation** at the request of the attending physician and physician's office calls;
11. the initial pair of **contacts** or eyeglasses following cataract surgery;
12. charges for injectable **contraceptives** (e.g., Depo Provera), transdermal patches, implantable contraceptives (e.g., Norplant), contraceptive devices (e.g. IUD, diaphragm, cervical cap), oral contraceptives, and surgical removal of contraceptive devices and implantable contraceptives;
13. **cosmetic surgery** if due to an accident;
14. **developmental delays** – ADHD and ADD are covered under this benefit;
15. **diabetes education/supplies** including blood glucose meters and glucose strips for home use in addition to:
 - diabetic self-management programs, training and education for the

treatment of all types of diabetes mellitus when prescribed by a licensed physician and provided by a state-certified program. This includes up to 10 hours of initial outpatient training provided within a 12-month period for each individual who meets any of the following conditions:

- A new onset of diabetes.
- Poor glycemic control as evidenced by a glycosylated hemoglobin of nine and five-tenths or more in the 90 days before attending the training.
- A change in the treatment regimen from no diabetes medications to any diabetes medications, or from oral diabetes medication to insulin.
- High risk for complications based on poor glycemic control; documented acute episodes of severe hypoglycemia or acute severe hyperglycemia occurring in the past year during which the individual needed third-party assistance for either emergency room visits or hospitalization.
- High risk based on documented complications of a lack of feeling in the foot or other foot complications such as foot ulcer or amputation, pre-proliferative or proliferative retinopathy or prior laser treatment of the eye, or kidney complications related to diabetes, such as macroalbuminuria or elevated creatinine.

An individual who received the initial training will be eligible for a follow-up session of as long as one hour annually.

16. **diagnostic x-ray service**;
17. charges for **drugs** and medicines that can only be obtained by a physician's prescription and insulin;
18. **durable medical and mechanical equipment**, rental limited to the purchase price. Must be medically necessary for the treatment of the patient, such as wheelchairs, hospital beds, and respirators (equipment that is not available for purchase will require continuous rental).

19. **elective surgical sterilization** such as tubal ligations and vasectomies;
20. **emergency room services**;
21. covered charges include reasonable and customary charges made by a hospital, by a physician, by a licensed physiotherapist or registered nurse (not a **family member**);
22. treatment for the following **foot conditions**: (a) weak, unstable or flat feet; (b) bunions, when an open cutting operation is performed; (c) non-routine treatment of corns or calluses; (d) toenails when at least part of the nail root is removed; (e) any medically necessary surgical procedure required for a foot condition; or (f) orthotics, including orthopedic shoes when an integral part of a leg brace;
23. **hemodialysis**;
24. **human papillomavirus (HPV) vaccine** - Gardasil
25. medically necessary **injectables** subject to the Plan limitations;
26. **laboratory tests** and other diagnostic services. Includes: MRI, MRA, CT Scans, EKG, EEG, Stress Tests;
27. **mammogram** (routine) as medically necessary or limited to:
 - one baseline between ages 35-39
 - one every two years between ages 40-49
 - one annually age 50 and over.
28. **massage therapy**;
29. **morbid obesity** exams, prescription drugs, surgery and diagnostic tests if the following criteria is met:
 - I. must be at least 18 years old;
 - II. documentation in the medical record of failure to sustain weight loss within the two years preceding surgery and documentation of the health care provider's monitoring of the patient's progress toward a goal of weight loss;
 - III. patient must be a motivated individual with acceptable operative risk and must be evaluated by a licensed mental health provider to determine the patient's willingness to comply with pre and postoperative treatment plans, and a strategy to ensure cooperation with follow-up must be documented. And, in addition to the general requirements above, the patient must also meet one of the following weight criteria:

- IV. BMI of 40kg/m² for at least three years; or
- V. BMI of greater than 35kg/m² in conjunction with at least one of the following:
 - Hypertension requiring medication for at least one year;
 - Diabetes mellitus type 2 requiring medication for at least one year;
 - Obstructive sleep apnea, confirmed by sleep study which does not respond to conservative treatment;
 - Documented cardiovascular disease;
 - Pulmonary hypertension of obesity;

Prior approval required.

30. **oxygen** and equipment for its administration;
31. **physical therapy** provided by a licensed physical therapist;
32. **physician's professional services** provided in a hospital's outpatient or emergency room facility, the physician's office, or the participant's home;
33. charges for **prosthetic appliances** used to aid in the function of or to replace a limb or organ if the appliance is the original appliance or a replacement required by pathological changes or normal growth. Limbs will be subject to the prosthetic deductible;
34. **radiation therapy** and **chemotherapy**;
35. **routine physical examinations**;
36. **speech, occupational, and inhalation/respiratory therapy** under the supervision of a physician. Speech therapy must be provided by a qualified provider to restore speech loss due to an illness, injury or surgical procedure. Occupational therapy supplies are not covered; and
37. surcharges and/or **taxes** for reimbursement of uncompensated care costs or other taxes imposed by a governmental body.

MEDICAL EXCLUSIONS

Certain medical services are not covered under this Plan; therefore, no claims will be paid on the following:

1. any charges which exceed a **benefit maximum**;
2. **blood**, blood plasma, and plasma expanders, and their administration, when available without charge (i.e. blood bank);
3. "**cash discounts**", over-the-counter (OTC) items, and sales tax.
4. **cosmetic surgery**, unless necessary due to an accident;
5. any charges for **custodial care**, domiciliary care, or rest cures except as specifically covered in the Hospice benefit. Additionally, expenses incurred for accommodations (including room and board and other institutional services) and nursing services for a participant because of age or a mental or physical condition primarily to assist the participant in daily living activities will be considered custodial care. The fact that the participant is also receiving medical services that are merely maintenance care that cannot reasonably be expected to substantially improve a medical condition will not prevent this limitation from applying;
6. **dental work** or treatment unless caused by an accidental injury or extraction of impacted teeth services that qualify for coverage under this Plan;
7. **educational testing** or training on account of nervous, mental, or emotional disorders;
8. treatment for an injury or sickness arising out of one's **employment for wage** or profit with any employer;
9. **experimental and investigational services**;
10. **eye examinations** (routine) or corrective lenses, eyeglasses, contact lenses or the fitting thereof, visual analysis or testing of visual acuity, biomicroscopy, field charting;
11. services with a diagnoses of "**family history**";
12. services provided by a **family member**, whether relationship is by blood or marriage, or by any person who regularly resides in the participant's home;
13. diagnosis and treatment of weak, strained or flat **feet** or instability or imbalance of the feet or any tarsalgia or bunion, other than operations involving the exposure of bones, tendons or ligaments, treatment (including cutting or removal by any method) of toe nails or of superficial lesions of the feet including corns, calluses, and hyperkeratoses other than the removal of nail matrix or root;
14. **genetic testing**;
15. any confinement, treatment, service, or supply in or by a **government owned** or operated facility, or where care is provided at government expense, i.e. a VA facility, unless there is legal obligation for the participant to pay for such treatment or service in the absence of coverage. If the injury or illness is non-service related, this Plan will be liable for benefits for covered services;
16. **hearing examinations or hearing aids** or for the fitting or repair of any hearing aid;
17. **hospital admissions** which are primarily for diagnostic evaluations, physical therapy, or occupational therapy, unless medically necessary;
18. **hospital and professional services** to which the **participant** is entitled **without charge** or to which the participant is entitled by any governmental program, except state Medicaid programs.
19. charges incurred while engaging in an **illegal** occupation, commission of or attempted commission of an assault or a felonious act;
20. any charges relating to **infertility** services;
21. **marital or family counseling**;
22. the portion of a charge for services and supplies in excess of the **maximum allowable fee**;

23. any injury sustained or illness contracted while on duty with any **military, naval, or air force** of any country or international organization or the result of an act of declared or undeclared war (including resistance to armed aggression) occurring while a participant under this Plan;
24. services and supplies for recreational or educational therapy or forms of **non-medical self-help or self-cure**;
25. **nonprescription medications**, vitamins, nutrients, and food supplements, even if prescribed or administered by a physician;
26. charges incurred while the participant is **not eligible** for coverage;
27. **personal convenience items**, including, but not limited to, air conditioners, or dehumidifiers, which can be used in the absence of an injury or illness;
28. treatment for any **pre-existing condition** as defined by this Plan;
29. **private duty nursing**;
30. **radial keratotomy** surgery if done for the purpose of correcting refractive errors;
31. **residential treatment facilities** with the exception of Psychiatric Medical Institution for Children (PMIC) Residential Facility;
32. charges due to insurrection or voluntary participation in a **riot**;
33. expenses applied toward **satisfaction of the deductible** or coinsurance expenses of this Plan;
34. any confinement, treatment, **service, or supply if not recommended and approved by a physician** and deemed to be not medically necessary for the condition of the participant, or any surgery or other type of medical treatment performed on an elective, non-medically necessary basis unless otherwise specified as covered by this Plan;
35. **sex transformation counseling or surgery**, or treatment related to a sexual dysfunction or a gender identification problem;
36. **temporomandibular joint syndrome**;
37. **tobacco cessation programs**, including any service or supply to eliminate or reduce the dependency on or addiction to tobacco; including, but not limited to, nicotine withdrawal programs, office visits and prescription drugs;
38. cost of **travel** or lodging related to obtaining medical treatment, or travel, even if recommended by a physician, unless specified as a covered benefit of this Plan; and
39. **wig**.

PRESCRIPTION CARD SERVICE BENEFITS

Prescription drug benefits are provided for coverage of a participant's prescription drug needs. Under Federal Law, they are only obtainable with a physician's prescription and may only be distributed by a licensed pharmacist. There is no coordination of benefits between prescription drug plans.

Option A: Prescription drugs can be purchased from any pharmacy. Prescription drug claims will be processed at the time of purchase with the Pharmacy Benefit Manager. The participant will pay 100% of the charge and will then be reimbursed by the Plan. This Plan will pay 80% of eligible charges once the calendar year deductible has been met. The drug identification card must be presented to the pharmacist when placing a prescription order.

Option B: Prescription drugs can be purchased from any participating pharmacy. The participant is required to pay a per prescription or refill co-pay at the time of purchase for up to a 34-day supply or 100-units, whichever is less as indicated on the benefit summary. The drug identification card must be presented to the pharmacist when placing a prescription order.

COVERED EXPENSES

Covered Expenses under the Prescription Card Services Benefits include charges for the following when prescribed by a Physician and dispensed by a licensed pharmacy:

- Drugs and medicines which, by federal law, require a written prescription to be dispensed, are listed in the U.S. Pharmacopoeia, and are approved by the United States Food and Drug Administration for the condition prescribed.
- Compounded medication.
- Any other drug which, under applicable law, may only be dispensed with the written prescription of a physician or other lawful prescriber.

NOT COVERED

No benefits are payable for expenses incurred:

- (1) for drugs obtained without a prescription order;
- (2) during a period of confinement in a hospital or other covered institution;
- (3) for vitamins (excluding prenatal vitamins);
- (4) for drugs consumed at the time and place of the prescription order, except drugs dispensed by a pharmacy doing business with the public;
- (5) for drugs covered under any governmental program or coverage provided or required by statute, except Medicaid, or for which no charge is incurred or there is no legal obligation to pay in the absence of insurance;
- (6) for a prescription or refill in excess of a 34-day supply;
- (7) for any prescription refill in excess of the number of refills specified by the physician, or any refill dispensed after one year from the date of the original prescription order;
- (8) for beauty aids, cosmetics or dietary supplements;
- (9) services needed due to an injury or illness relating to employment with any employer, including self-employment;
- (10) therapeutic devices or appliances; or
- (11) administration of drugs, including insulin.

MAIL ORDER PRESCRIPTION DRUG BENEFITS

This Plan includes a mail order drug benefit for the purchase of maintenance drugs. Maintenance drugs are those medications which a physician has prescribed to treat an ongoing condition such as high blood pressure, diabetes or heart condition.

Option A: The mail order drug program is administered by NPS (National Pharmaceutical Services) and helps save money by providing as much as a 90-day supply. The participant is required to pay 100% of the charge and will then be reimbursed by the Plan. The medical deductible and out-of-pocket maximum will apply.

Option B: The mail order drug program is administered by NPS (National Pharmaceutical Services) and helps save money by providing as much as a 90-day supply for one co-pay. The participant is required to pay the generic/preferred brand/non preferred brand name prescription co-pay as shown in the benefit summary at the time of purchase.

Please refer to the benefit summary for specific limitations.

Important Note: If the participant disagrees with a reduction in or denial of benefits, please see the Claims Review Procedure sections for information on how to file an appeal. This section outlines the time frames in which the Plan must respond to a participant's claim and/or appeal.

EMPLOYEE COVERAGE AND ELIGIBILITY

EMPLOYEE ELIGIBILITY

An employee is eligible for health coverage if he/she is a regular employee who is scheduled to work no less than 20 hours each week. If the employee ceases to work, or is no longer scheduled to work at least 20 hours each week, he/she ceases to be a covered employee under this Plan. If, as a 20 hour per week employee, he/she declined family coverage, he/she will be eligible to add family coverage if his/her status changes to a 40-hour per week employee.

Seasonal employees who work full time for a minimum of four months and a maximum of eight months are also eligible for health coverage under this Plan.

EMPLOYEE ENROLLMENT AND EFFECTIVE DATE

This Plan is effective on the first day of the month following date of hire providing he/she enrolls for coverage within 31 days from the date you are eligible.

If the employee is eligible for coverage, but not actively at work on the day his/her coverage is scheduled to begin because of any reason other than his/her own medical condition or disability, this Plan will become effective the day the employee returns to active work. This actively-at-work provision will not delay the effective date of coverage if the sole reason the employee is not working is because the day is not a regularly scheduled workday.

If the employee does not apply to become a covered employee by completing an enrollment form or application within the 31-day period following the date he/she becomes eligible, the employee will not be eligible for coverage under this Plan except during a special enrollment period. **This Plan does not have an Open Enrollment provision.**

EMPLOYEE TERMINATION OF COVERAGE

Coverage will end on the earliest of the following dates:

- a) the date this Plan is terminated with respect to the company, and there is no successor plan;
- b) the last day of the month on which the covered employee ceases to be a covered employee;
- c) the last day of the month in which the covered employee's active employment with the City is terminated;
- d) the last day of the month the covered employee ceases to be in a class of employees eligible for coverage;
- e) the end of the period for which the covered employee has made contributions if the next required contribution is not made;
- f) the last day of the month the covered employee voluntarily elect to be terminated from this Plan, subject to the pre-tax premium rules as outlined in this booklet.

If the covered employee ceases active employment due to layoff or an authorized leave of absence, participation may be continued pursuant to rules adopted by the City and applied on a uniform basis to all covered employees similarly situated.

Notwithstanding the foregoing provision, participation may be continued if the covered employee is on an approved disability leave of absence pursuant to rules adopted by the City and applied to all covered employees similarly situated on a uniform basis.

If the covered employee wishes to cancel coverage, he/she must notify the employer within 31 days of the desired date of cancellation.

Unless otherwise specified under this Plan, when coverage terminates, benefits will not be provided for any services after the termination date even though the services are furnished as a result of an injury or illness that occurred prior to termination of coverage.

RETIREE ELIGIBILITY

Coverage for injuries or diseases, as defined by the Iowa Code, incurred while in the performance of their duties is provided for police and fire personnel who are receiving a retirement allowance. Benefits provided by this Plan will be coordinated with any benefits received through Workers' Compensation or any other coverage available.

Under Iowa Code, Section 509(A), regular employees who retire with the City of Urbandale, who are enrolled in the City's health Plan, and are under the age of 65, are eligible to continue participation in the City's group health Plan at the retiree's expense.

Under Iowa Code, Section 509(B), the eligible (as stated above) retiree's spouse is also eligible to enroll in the City's health Plan, if the spouse is under the age of 65 and the member was enrolled in the family plan prior to retiring. The cost of the health plan will be at the retiree's expense.

To continue coverage as a retiree, he/she must meet the following retirement scenario:

- a regular employee who retires with the City of Urbandale and are enrolled in the City's health Plan; and
- are under the age of 65.

Employees retiring between the ages of 62 and 65 will receive one month paid **single** health insurance coverage for each continuous year of service. An employee retiring due to disability will have this same benefit.

An employee who satisfies the guidelines of his/her pension plan, has not reached the age of 62, and can certify that they have no other insurance option available, may utilize 50% of their sick leave to pay for the "single" health insurance premium. The remainder of the premium would be paid by the City. This benefit will remain in place until the sick leave is exhausted or the employee reaches the end of the payout period (one month of coverage for each year of service).

Deferred Enrollment

If an employee is eligible to retire under either scenario discussed above, and has either single or family coverage at the time of retirement, and that employee has the availability to obtain insurance coverage through another source, the employee may elect to defer their enrollment under the City's retiree health plan until such

time as they have a special enrollment right (See Special Enrollment Periods section).

The deferral option may be applied for the later of:

1. initial retirement eligibility date, or
2. the date the retiree's years of service benefit (as described in scenario #1 above) expires.

A deferral election form must be completed by the employee/retiree and submitted to the City's Finance & Records Department within 30 days of the actual deferral effective date. If the eligible retiree elects to use the deferral at their initial retirement date (prior to using the years of service benefit), any years of service benefit earned will be forfeited, and cannot be used at a later time or converted into a cash payment.

After exercising the deferral, and upon the occurrence of a special enrollment event, if the retiree chooses to return to the City's retiree insurance plan, the retiree must notify the Finance & Records Department within 30 days of the event, and complete an enrollment form for the retiree and spouse/dependents (if eligible). Premiums will be the responsibility of the retiree and will be based on current health plan retiree premium rates.

RETIREE TERMINATION OF COVERAGE

Coverage will end on the earliest of the following dates:

- a) participation in the City's group health Plan (whether single or family) ceases when the employee reaches the age of 65;
- b) the date this Plan is terminated with respect to the company, and there is no successor plan;
- c) the end of the period for which the retiree have made contributions if the retiree fails to make the next required contribution;
- d) the last day of the month the retiree voluntarily elect to be terminated from this Plan, subject to the pre-tax premium rules as outlined in this booklet.

If the retiree wishes to cancel coverage, he/she must notify the employer within 31 days of the desired date of cancellation.

Unless otherwise specified under this Plan, when coverage terminates, benefits will not be provided for any services after the termination

date even though the services are furnished as a result of an injury or illness that occurred prior to termination of coverage.

DEPENDENT ELIGIBILITY

A covered employee may choose to cover his/her dependents (as defined) under this Plan.

Evidence of common law marriage status must be provided at the time the employee chooses to enroll his/her spouse for coverage if they are a common law spouse.

A covered employee's dependent children can be covered until they reach the age of 26. Coverage will continue through the **end** of the month that they turn 26. They may continue coverage beyond age 26 if they are unmarried, full-time students in an accredited school.

Dependent children include natural children, adopted children (as defined) and stepchildren.

No person may be covered as both an employee and a dependent under this Plan. Likewise, no person may be a covered dependent of more than one covered employee under this Plan.

Michelle's Law: Coverage of Dependent Students on Medically Necessary Leave of Absence

In the case of an eligible dependent child, this Plan shall not terminate coverage due to a medically necessary leave of absence from, or any other change in enrollment at, a post-secondary education institution that commences while such dependent child is suffering from a serious illness or injury that causes such dependent child to lose student status for purposes of coverage under this Plan, before the earlier of:

- (a) up to one year after the beginning of the leave of absence; or
- (b) the date coverage would otherwise terminate under the Plan.

For the student to qualify for this extension, the plan must receive written certification from his/her treating physician stating that the student is suffering from a serious illness or injury and that the leave of absence is medically necessary.

A student will qualify for a medically necessary leave of absence from a post-secondary educational institution if the leave of absence:

- (a) begins while the child is suffering from a serious illness or injury;

- (b) is certified by a physician as being medically necessary; and
- (c) causes the child to lose student status for purposes of coverage under the plan.

If the dependent child's treating physician does not provide written documentation that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary, this Plan will not provide continued coverage.

Adopted Child

The term "dependent" found in this Plan shall include any child meeting the dependent eligibility requirements of this Plan who has been placed for adoption or who has been adopted by the participant.

Such a child shall be eligible for coverage as of the date of placement for adoption, or as of the date of actual adoption, whichever occurs first.

Coverage under this Plan for the adopted child shall be the same coverage which is available to all other dependent children under this Plan except that additional waiting periods will be waived for such a child provided the child is enrolled within the time periods specified under the section entitled **Dependent Enrollment and Effective Date**.

QMCSO Provision

This Plan will provide benefits to the child(ren) of a participant if a Qualified Medical Child Support Order (QMCSO) is issued regardless of whether the child(ren) reside with the participant. If a QMCSO is issued, then the child(ren) shall become alternate recipient(s) of the benefits under this Plan, subject to the same limitations, restrictions, provisions and procedures as any other participant. A properly completed National Medical Support Notice (NMSN) will be treated as a QMCSO and will have the same force and effect.

Procedural QMCSO Requirements

Within a reasonable period of time following receipt of a medical child support order the Plan Administrator will notify the participant and each child specified in the order whether the order is or is not a Qualified Medical Child Support Order. A QMCSO is an order which creates or recognizes the right of an alternate recipient (participant's child who is recognized under the order as having a right to be enrolled under this Plan) or assigns to the alternate recipient the right to receive benefits.

To be considered a Qualified Medical Child Support Order the medical child support order must contain the following information:

- The name and last known mailing address of the participant and the name and address of each child to be covered by this Plan.
- A reasonable description of the type of coverage to be provided by this Plan to each named child, or the manner in which the type of coverage is to be determined.
- The period to which such order applies.

If the order **is** determined to be a Qualified Order, each named child will be covered by this Plan in the same manner as any other dependent child is covered by this Plan.

Coverage for a child under a QMCSO will begin on the latest of the following dates:

- a) If the employee already has coverage in force, the child will be covered as of the date specified in the order or, if no date is specified in the Order, the date the QMCSO is received;
- b) If the employee is within the waiting period as specified under the section entitled "Effective Date", the child's coverage will become effective the same date the employee's coverage is effective; or
- c) If the employee is otherwise eligible but previously waived coverage, the employee's and the child's coverage will become effective as of the date specified in (a) above.

Each named child will be considered a participant under this Plan but may designate another person, such as a custodial parent or legal guardian, to receive copies of explanations of benefits, checks and other material that which would otherwise be sent directly to the named child.

If it is determined that the order **is not** a Qualified Order, each named child may appeal that decision by submitting a written letter of appeal to the Plan Administrator. The Plan Administrator shall review the appeal and reply in writing within 30 days of receipt of the appeal.

This Plan will not provide any type or form of benefit, or any option, not otherwise provided under this Plan and all other dependent eligibility, effective date and termination provisions will apply.

DEPENDENT ENROLLMENT AND EFFECTIVE DATE

Generally, coverage for dependents will become effective on the same day the employee's coverage begins. Any new dependent can become a covered dependent as of one of the following applicable dates:

- a) the eligibility date for which written application is made and delivered to the Plan Administrator, if made on or before the date the individual becomes a dependent;
- b) the eligibility date for which such written application is received when the application is made and delivered to the Plan Administrator within 31 days after the individual becomes a dependent; or
- c) the eligibility date determined under the terms of an applicable Special Enrollment period. In some cases, such as marriage, birth, adoption, and placement for adoption, there may be special circumstances that will allow a dependent to enroll for coverage after the initial enrollment period. For further details on these circumstances, see the section on **Special Enrollment Periods**.

If the employee is absent from active work because of any reason other than his/her medical condition or disability when coverage for his/her dependents would otherwise take effect, coverage for the dependents will become effective only upon the employee's return to active work.

DEPENDENT TERMINATION OF COVERAGE

Dependents' coverage will end on the earliest of the following dates:

- a) For dependent spouse:
 - In the event of a legal separation or divorce, coverage for the employee's spouse ceases the end of the month in which the event occurred;
 - the date this Plan is terminated with respect to the company, and there is no successor plan;

- the end of the period for which the employee has made contributions for a dependent's coverage if the next required contribution is not made.

b) For dependent children:

- the date this Plan is terminated with respect to the company, and there is no successor plan;
- the last day of the month in which he/she ceases to be a dependent child, as defined by this Plan if child is under age 26;
- the last day of the plan year in which the dependent child ceases to be a full-time student, as defined by this Plan, and is 26 years of age or older;
- the end of the period for which the employee has made contributions for a dependent's coverage if the next required contribution is not made.

If the participant wishes to cancel coverage, he/she must notify the employer within 31 days of the desired date of cancellation.

Unless otherwise specified under this Plan, when coverage terminates, benefits will not be provided for any services after the termination date even though the services are furnished as a result of an injury or illness that occurred prior to termination of coverage.

SPECIAL ENROLLMENT PERIODS

Special Enrollment rights are provided both to current employees who were eligible but declined enrollment in the Plan when first offered because they were covered under another plan and to individuals acquiring a dependent.

If an individual moves from a high deductible plan to a low deductible plan mid-year, there will be no reimbursement if the high deductible has already been met.

This Plan will permit a current employee who is already enrolled in a Plan option to enroll in another Plan option under this Plan in the event of a Special Enrollment right.

Pre-existing condition exclusion periods for special enrollees may not exceed 12 months.

Individuals Losing Other Coverage

This Plan will permit a current employee or dependent who is eligible, but not enrolled, to enroll for coverage under the terms of this Plan if **each** of the following conditions are met:

- the current employee or dependent was covered under another group health plan or had other health insurance coverage at the time coverage under this Plan was offered;
- the current employee stated in writing at the time this Plan was offered, that the reason for declining enrollment was due to the current employee having coverage under another group health plan or due to having other health insurance coverage, but only if this Plan required such a written statement at that time and provided the current employee with notice of the requirement (and consequences of the requirement) at that time;
- the current employee or dependent lost other coverage pursuant to one of the following events:
 - the current employee or dependent was under COBRA and the COBRA coverage was exhausted;
 - the current employee or dependent was not under COBRA and the other coverage was terminated as a result of loss of eligibility (including as a result of legal separation, divorce, loss of dependent status, death, termination of employment, or reduction in the number of hours worked);
 - the current employee or dependent moved out of an HMO service area with no other option available;
 - the current employee or dependent met or exceeded a lifetime limit on all benefits (the event for reaching the lifetime limit is the earliest date that a claim is denied);
 - the Plan is no longer offering benefits to a class of similarly situated individuals;
 - the benefit package option is no longer being offered and no substitute is available; or
 - the employer contributions were terminated; and

- (d) under the terms of this Plan, the current employee requests enrollment into this Plan not later than 30 days after an event, as described in (c) above.

For an eligible current employee or dependent who has met each of the conditions specified above, this Plan will be effective on the date of the loss of other coverage.

This Plan will also permit a current employee or dependent who is eligible, but not enrolled, to enroll for coverage under the terms of this Plan if the current employee or dependent lost eligibility under Medicaid or Children's Health Insurance Program (CHIP).

The current employee must request enrollment into this Plan not later than 60 days after the event, as described above.

Dependent Beneficiaries

This Plan will provide for a dependent special enrollment period during which the person may be enrolled under this Plan as a dependent of the current employee (and, if not otherwise enrolled, the current employee or spouse may be enrolled at the same time):

- (a) if the current employee has coverage under this Plan (or the current employee has met any waiting period applicable to becoming covered under this Plan and are eligible to be enrolled under this Plan, but failed to enroll during a previous enrollment period); and
- (b) if a person becomes a dependent of the current employee through marriage, birth, or adoption or placement for adoption.

The dependent special enrollment period will be a period of 30 days beginning on the date of marriage and will require an enrollment application. The dependent special enrollment period will be a period of 60 days beginning on the date of birth, adoption or placement for adoption and will require an enrollment application.

If a current employee requests enrollment for a dependent during the dependent special enrollment period, the coverage for the dependent will become effective:

- (a) in the case of marriage, as of the date of marriage;
- (b) in the case of a dependent's birth, as of the date of birth; or

- (c) in the case of a dependent's adoption or placement for adoption, as of the date of the adoption or placement for adoption.

If the covered current employee has family coverage, newborns are automatically covered under this Plan from the moment of birth. An enrollment form or application will be required.

This Plan will provide for a dependent special enrollment period during which the person may be enrolled under this Plan as a dependent of the current employee (and, if not otherwise enrolled, the current employee and/or spouse may be enrolled at the same time) if:

- the current employee or dependent becomes eligible for a new premium assistance subsidy plan under Medicaid or Children's Health Insurance Program (CHIP).

This dependent special enrollment period will be a period of 60 days beginning on the date of eligibility.

If a current employee requests enrollment for a dependent during the dependent special enrollment period, the coverage for the dependent will become effective as of the first day of the month after the request for enrollment is received.

DEPENDENT CHILDREN WITH DISABILITIES

Coverage of a dependent child shall not cease, because of attainment of the termination age specified in this Plan, while the employee's coverage is in force if the child:

- (a) is unmarried;
- (b) is incapable of self-sustaining employment by reason of a permanent, handicapping mental or physical disability; and
- (c) became so disabled prior to attainment of the termination age specified in this Plan.

The participant must submit to the City of Urbandale, within 31 days of such dependent's attainment of the termination age, written proof of the incapacity as described herein and continues to pay premiums, if any, for the dependent's coverage. The coverage of any such dependent shall be subject to the termination provisions of this Plan.

The City, upon receipt of proof of the disability, shall have the right and opportunity to have a physician it designates examine any such dependent when and as often as it may reasonably require.

The City will not require the dependent to be examined more than once each year after such disability has continued on an uninterrupted basis for at least two years following the date the initial written proof of disability was received.

All rights under the provisions of this section shall automatically and immediately cease on the earliest of the following dates:

- (a) the date the dependent's disability as described no longer exists;
- (b) the date the dependent fails to submit to any required medical examination;
- (c) the date any required proof of the uninterrupted existence of the dependent's disability is not submitted; or
- (d) the date the dependent otherwise ceases to qualify as a dependent except for the attainment of the maximum age as specified by this Plan.

FRAUD OR MISREPRESENTATION OF MATERIAL FACTS

Coverage will terminate immediately if a participant uses this Plan fraudulently or fraudulently misrepresents a material fact in his/her application.

If coverage is terminated for fraud or misrepresentation of a material fact, the Plan has the right to recover any/all claim payments and retains the right to pursue any/all other legal rights, including the right to bring a civil action.

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

The Plan Sponsor shall fully comply with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If any part of this Plan is found to be in conflict with this Act, the conflicting provision shall be null and void. All other benefits and exclusions of the Plan will remain effective to the extent there is no conflict with this Act.

USERRA provides for, among other employment rights and benefits, continuation of health care coverage to a covered employee and covered dependents, during a period of active service or training with any of the Uniformed Services. The Plan provides that a covered employee may

elect to continue such coverages in effect at the time the employee is called to active service. The maximum period of coverage for the employee and the covered employee's dependents under such an election shall be the lesser of:

- the 24-month period beginning on the date on which the covered employee's absence begins; or

- the period beginning on the date on which the covered employee's absence begins and ending on the day after the date on which the covered employee fails to apply for or return to a position of employment as follows:

- for service of less than 31 days, no later than the beginning of the first full regularly scheduled work period on the first full calendar day following the completion of the period of service and the expiration of eight hours after a period allowing for the safe transportation from the place of service to the covered employee's residence or as soon as reasonably possible after such eight hour period;

- for service of more than 30 days but less than 181 days, no later than 14 days after the completion of the period of service or as soon as reasonably possible after such period;

- for service of more than 180 days, no later than 90 days after the completion of the period of service; or

- for a covered employee who is hospitalized or convalescing from an illness or injury incurred in or aggravated during the performance of service in the uniformed services, at the end of the period that is necessary for the covered employee to recover from such illness or injury. Such period of recovery may not exceed two years.

A covered employee who elects to continue health plan coverage under the Plan during a period of active service in the Uniformed Services may be required to pay not more than 102% of the full premium under the plan associated with such coverage for the employer's other employees, except that in the case of a covered employee who performs service in the uniformed services for less than 31 days, such covered employee may not be required to pay more than the employee share, if any, for such coverage. Continuation coverage cannot be discontinued merely because

activated military personnel receive health coverage as active duty members of the Uniformed Services, and their family members are eligible to receive coverage under the Department of Defense's managed health care program, TRICARE.

In the case of a covered employee whose coverage under a health plan was terminated by reason of services in the Uniformed Services, the pre-existing exclusion and waiting period may not be imposed in connection with the reinstatement of such coverage upon reemployment under this Act. This applies to the covered employee who is reemployed and any dependent whose coverage is reinstated. The waiver of the pre-existing exclusion shall not apply to illness or injury which occurred or was aggravated during performance of service in the Uniformed Services.

"Uniformed Services" shall include full time and reserve components of the United States Army, Navy, Air Force, Marines, Coast Guard, Army National Guard, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

If the participant is a covered employee called to a period of active service in the Uniformed Service, the participant should check with the Plan Administrator for a more complete explanation of his/her rights and obligations under USERRA.

FAMILY AND MEDICAL LEAVE ACT OF 1993

This Section only applies to employers required to comply with the Federal Family and Medical Leave Act.

ENTITLEMENT TO LEAVE

This Act requires an employer which employs 50 or more employees (within a 75-mile radius) to allow an employee who has been employed for 12 months or more and accumulated hours of service in excess of 1,250 hours from the date of employment or the end of the last qualified leave, to take a total of 12 weeks of leave during any 12-month period, as defined by the employer, for:

- (a) the birth of a son or daughter of the employee and in order to care for such son or daughter;

- (b) placement of a son or daughter with the employee for adoption or foster care;
- (c) care for a spouse, son, daughter, or parent of the employee, if such spouse, son, daughter, or parent has a serious health condition;
- (d) a serious health condition that makes the employee unable to perform the functions of the position of such employee; or
- (e) a qualifying exigency arising out of the fact that the spouse, son, daughter, or parent of the employee is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation.

EXPIRATION OF ENTITLEMENT

The entitlement to leave under subparagraphs (a) and (b) of Entitlement to Leave for a birth or placement of a son or daughter shall expire at the end of the 12-month period beginning on the date of such birth or placement.

SERVICEMEMBER FAMILY LEAVE

An eligible employee who is the spouse, son, daughter, parent or next of kin of a covered servicemember shall be entitled to a total of 26 workweeks of leave during a single 12-month period to care for the servicemember. The leave described in this paragraph shall only be available during a single 12-month period.

COMBINED TOTAL LEAVE

During the single 12-month period as described in Servicemember Family Leave, an eligible employee shall be entitled to a combined total of 26 workweeks of leave under Entitlement to Leave and Servicemember Family Leave. Nothing in this paragraph shall be construed to limit the availability of leave under Entitlement to Leave during any other 12-month period.

Any employee taking a leave shall be entitled to continue to use his/her benefits during the duration of the leave if he/she participates in a "group health plan" as defined in §5000(b)(1) of the Internal Revenue Code of 1986. The employer must continue the benefits at the level and under the conditions of coverage that would have been provided if the employee had remained employed. If the employee who is responsible for payment misses a premium payment during the leave of absence, the employer may terminate coverage provided that the employee has been given

notification of termination and a grace period as defined by the FMLA. If the benefits are terminated during the leave, the employee is entitled to be fully reinstated upon returning to work. If the employee for any reason fails to return from the leave, the employer may recover from the employee the premium or portion of the premium that the employer paid, provided the employee fails to return to work for any reason other than the recurrence of the health condition or circumstances beyond the control of the employee.

Leave taken under the Act does not constitute a "qualifying event" so as to trigger COBRA rights. However, a qualifying event triggering COBRA coverage may occur when it becomes known that the employee is not returning to work. Therefore, if an employee does not return at the end of 12 weeks Family and Medical Leave, the COBRA qualifying event occurs at that time.

This is only a summary of the Family and Medical Leave Act of 1993. Please contact the employer for more information.

COVERAGE CONTINUATION UNDER FEDERAL LAW - COBRA

The following information about the participant's right to continue his/her health care coverage in the Plan is important. Please read it very carefully.

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end. The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to the participant when he/she would otherwise lose group health coverage under the Plan. It can also become available to the participant's spouse and dependent children, if they are covered under the Plan, when they would otherwise lose their group health coverage under the Plan. The following paragraphs generally explain COBRA coverage, when it may become available to the participant and his/her family, and what the participant needs to do to protect the right to receive it.

COBRA (and the description of COBRA coverage contained in this Plan) applies only to the group health plan benefits offered under the

Medical Plan and not to any other benefits offered under the Plan or by City of Urbandale (such as life insurance, disability, or accidental death or dismemberment benefits). The Plan provides no greater COBRA rights than what COBRA requires – nothing in this Plan is intended to expand the participant's rights beyond COBRA's requirements.

For additional information about the participant's rights and obligations under the Plan and under federal law, the participant should contact First Administrators, Inc., which is the Benefits Services Administrator or City of Urbandale, which is the Plan Administrator.

WHAT IS COBRA COVERAGE?

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed below in the section entitled "Who is Entitled to Elect COBRA?"

After a qualifying event occurs and any required notice of that event is properly provided to the Plan Administrator, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary". The participant, his/her spouse, and dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under QMCSO's may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

COBRA coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will have the same rights under the Plan as other participants or beneficiaries covered under the component or components of the Plan elected by the qualified beneficiary, including special enrollment rights. Under the Plan, qualified beneficiaries who elect COBRA must pay for COBRA coverage.

Additional information about the Medical component of the Plan is available in other portions of this Plan.

WHO IS ENTITLED TO ELECT COBRA?

The employee will be entitled to elect COBRA if he/she loses his/her group health coverage

under the Plan because his/her hours of employment are reduced; or his/her employment ends for any reason other than his/her gross misconduct.

As the spouse of an employee, the spouse will be entitled to elect COBRA if he/she loses his/her group health coverage under the Plan because any of the following qualifying events happens:

- the employee dies;
- the employee's hours of employment are reduced;
- the employee's employment ends for any reason other than his or her gross misconduct;
- the employee becomes entitled to Medicare benefits prior to his/her qualifying event; or
- the spouse becomes divorced or legally separated from the employee.

As the dependent child of an employee, the dependent child will be entitled to elect COBRA if he/she loses his/her group health coverage under the Plan because any of the following qualifying events happens:

- the parent-employee dies;
- the parent-employee's hours of employment are reduced;
- the parent-employee's employment ends for any reason other than his or her gross misconduct;
- the parent-employee becomes entitled to Medicare benefits;
- the parents become divorced or legally separated; or
- the dependent stops being eligible for coverage under the Plan as a "dependent child".

If an employee takes FMLA leave and does not return to work at the end of the leave, the employee (and the employee's spouse and dependent children, if any) will be entitled to elect COBRA if (1) they were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and (2) they will lose Plan coverage within 18 months because of the employee's failure to return to work at the end of the leave. (This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the Plan during the leave.) COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period (subject to extension or early

termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours. (See the section below entitled "Length of COBRA Coverage".)

WHEN IS COBRA COVERAGE AVAILABLE?

When the qualifying event is the end of employment, reduction of hours of employment or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. The participant need not notify the Plan Administrator of any of these three qualifying events.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available only if the participant notifies the Plan Administrator in writing within 60 days after the later of (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

The written notice must include the Plan name or group name, the employee's name, the employee's Social Security Number, the dependent's name and a description of the event.

If these procedures are not followed or if the written notice is not provided to the Plan Administrator during the 60-day notice period, **THE PARTICIPANT WILL LOSE HIS/HER RIGHT TO ELECT COBRA.**

ELECTING COBRA COVERAGE

To elect COBRA, the participant must complete the Election Form that is part of the Plan's COBRA election notice and submit it to the Plan Administrator (An election notice will be provided to qualified beneficiaries at the time of a qualifying event. The participant may also obtain a copy of the Election Form from the Plan Administrator. Under federal law, the participant must have 60 days after the date the qualified beneficiary Plan coverage terminates, or, if later, 60 days after the date of the COBRA election notice provided to him/her at the time of his/her qualifying event to decide whether he/she wants to elect COBRA under the Plan.

Mail the completed Election Form to:

COBRA Specialist
Bernie Lowe & Associates, Inc.
1555 SE Delaware Ave, Suite A

Ankeny, IA 50021

The Election Form must be completed in writing and mailed to the individual and address specified above. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage, and electronic communications, including email and faxed communications.

The election must be postmarked no later than 60 days after the date of the COBRA election notice provided at the time of the qualifying event. **IF THE PARTICIPANT DOES NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, HE/SHE WILL LOSE HIS OR HER RIGHT TO ELECT COBRA.**

If the participant rejects COBRA before the due date, he/she may change his/her mind as long as he/she furnishes a completed Election Form before the due date.

The participant does not have to send any payment with his/her Election Form when he/she elects COBRA. Important additional information about payment for COBRA coverage is included below.

Each qualified beneficiary will have an independent right to elect COBRA. For example, the employee's spouse may elect COBRA even if the employee does not. COBRA may be elected for only one, several, or for all dependent children who are qualified beneficiaries. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their children. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice **WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.**

When the participant completes the Election Form, he/she must notify the Plan Administrator if any qualified beneficiary has become entitled to Medicare and, if so, the date of Medicare entitlement. If the participant becomes entitled to Medicare (or first learns that he/she is entitled to Medicare) after submitting the Election Form, immediately notify the Plan Administrator of the date of the Medicare entitlement at the address specified above for delivery of the Election Form.

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to

Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable pre-existing condition exclusions of that other plan have been exhausted or satisfied). See the section below entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period".

SPECIAL CONSIDERATIONS IN DECIDING WHETHER TO ELECT COBRA

In considering whether to elect COBRA, the participant should take into account that a failure to elect COBRA will affect his/her future rights under federal law. First, he/she can lose the right to avoid having pre-existing condition exclusions applied to the participant by other group health plans if he/she has a 63-day gap in health coverage, and election of COBRA may help avoid such a gap. Second, the participant will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if he/she elects COBRA coverage and does not exhaust COBRA coverage for the maximum time available. Finally, the participant should take into account that he/she has special enrollment rights under federal law. The participant has the right to request special enrollment in another group health plan for which he/she is otherwise eligible (such as a plan sponsored by the spouse's employer) within 30 days after the participant's group health coverage under the Plan ends because of one of the qualifying events listed above. The participant will also have the same special enrollment right at the end of COBRA coverage if he/she gets COBRA coverage for the maximum time available.

LENGTH OF COBRA COVERAGE

COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described below are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage period for several reasons, which are described in the section below entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period".

When plan coverage is lost due to the death of the employee, the covered employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA coverage can last for up to a total of 36 months.

When plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his/her employment terminates, COBRA coverage under the Plan's Medical component for his/her spouse and children who lost coverage as a result of his/her termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

Otherwise, when Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, COBRA coverage generally can last for only up to a total of 18 months.

EXTENSION OF MAXIMUM COVERAGE PERIOD

If the qualifying event that resulted in the participant's COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. The participant must notify the Plan Administrator of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA coverage. Along with the notice of a disability, the qualified beneficiary must also supply a copy of the Social Security Administration disability determination.

If a qualified beneficiary is determined by the Social Security Administration to be disabled and the participant notifies the Plan

Administrator in a timely fashion, all of the qualified beneficiaries in the family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The qualified beneficiary must be determined disabled at any time during the first 60 days of COBRA coverage. Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if the participant notifies the Plan Administrator in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date of the covered employee's termination of employment or reduction of hours; or
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

The written notice must include the Plan name or group name, the employee's name, the employee's Social Security Number, the dependent's name and a description of the event.

The participant must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension.

If these procedures are not followed or if the written notice is not provided to the Plan Administrator during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, **THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.**

An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage

available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when a covered employee becomes entitled to Medicare.)

This extension due to a second qualifying event is available only if the participant notifies the Plan Administrator in writing of the second qualifying event within 60 days after the later of (1) the date of the second qualifying event; and (2) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan).

If these procedures are not followed or if the written notice is not provided to the Plan Administrator during the 60-day notice period, **THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.**

In addition to the regular COBRA termination events specified later in this section, the disability extension period will end the first of the month beginning more than 30 days following recovery.

Example: If disability ends June 10, coverage will continue through the month of July (7/31).

TERMINATION OF COBRA COVERAGE BEFORE THE END OF THE MAXIMUM COVERAGE PERIOD

COBRA coverage will automatically terminate before the end of the maximum period if:

- any required premium is not paid in full on time;
- a qualified beneficiary becomes covered, after electing COBRA, under another group health plan (but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the qualified beneficiary have been exhausted or satisfied);
- a qualified beneficiary becomes entitled to Medicare benefits after electing COBRA;

- the employer ceases to provide any group health plan for its employees; or
- during a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled. For more information about the disability extension period, see the section above entitled "Extension of Maximum Coverage Period".

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

The participant must notify the Plan Administrator in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the qualified beneficiary have been exhausted or satisfied).

COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of any pre-existing condition exclusions for a pre-existing condition of the qualified beneficiary). The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when the participant provides notice to the Plan Administrator of Medicare entitlement or other group health plan coverage.

If a disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled, the participant must notify the Plan Administrator of that fact within 30 days after the Social Security Administration's determination.

If the Social Security Administration's determination that the qualified beneficiary is no longer disabled occurs during a disability extension period, COBRA coverage for all qualified beneficiaries will terminate (retroactively if applicable) as of the first day of the month that is more than 30 days after the Social Security Administration's determination that the qualified beneficiary is no longer disabled. City of Urbandale will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when the participant provides notice to the Plan Administrator that the disabled qualified beneficiary is no longer disabled. (For more

information about the disability extension period, see the section above entitled “Extension of Maximum Coverage Period”.)

COST OF COBRA COVERAGE

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to a disability, 150%) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage. The amount of the COBRA premiums may change from time to time during the period of COBRA coverage and will most likely increase over time. The participant will be notified of COBRA premium changes.

PAYMENT FOR COBRA COVERAGE

All COBRA premiums must be paid by check or money order.

The participant’s first payment and all monthly payments for COBRA coverage must be made payable to Bernie Lowe & Associates, Inc. and mailed to:

Bernie Lowe & Associates, Inc.
1555 SE Delaware Ave., Suite A
Ankeny, IA 50021

The payment is considered to have been made on the date that it is postmarked. The participant will not be considered to have made any payment by mailing a check if his/her check is returned due to insufficient funds or otherwise.

If the participant elects COBRA, he/she does not have to send any payment with the Election Form. However, he/she must make his/her first payment for COBRA coverage not later than 45 days after the date of election. (This is the date the Election Form is postmarked, if mailed, or the date the Election Form is received by the individual at the address specified for delivery of the Election Form, if hand-delivered). See the section above entitled “Electing COBRA Coverage”.

The first payment must cover the cost of COBRA coverage from the time coverage under the Plan would have otherwise terminated up through the end of the month before the month in which the participant makes his/her first payment. (For example, Sue’s employment terminated on

September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of her COBRA election). The participant is responsible for making sure that the amount of his/her first payment is correct. He/she may contact the Plan Administrator using the contact information provided below to confirm the correct amount of the first payment.

Claims for reimbursement will not be processed and paid until the participant has elected COBRA and made the first payment for it.

If the participant does not make the first payment for COBRA coverage in full within 45 days after the date of his/her election, he/she will lose all COBRA rights under the plan.

After the participant makes his/her first payment for COBRA coverage, he/she will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided at the time of the qualifying event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month’s COBRA coverage. If the participant makes a monthly payment on or before the first day of the month to which it applies, his/her COBRA coverage under the Plan will continue for that month without any break. The Plan Administrator will not send periodic notices of payments due for these coverage periods (that is, we will not send a bill for the COBRA coverage – it is the participant’s responsibility to pay his/her COBRA premiums on time).

Although monthly payments are due on the first day of each month of COBRA coverage, the participant will be given a grace period of 30 days after the first day of the month to make each monthly payment. COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if the participant pays a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, his/her coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim submitted for benefits while coverage is suspended may be denied and may have to be resubmitted once coverage is reinstated.

If the participant fails to make a monthly payment before the end of the grace period for that month, **HE OR SHE WILL LOSE ALL RIGHTS TO COBRA COVERAGE UNDER THE PLAN.**

MORE INFORMATION ABOUT INDIVIDUALS WHO MAY BE QUALIFIED BENEFICIARIES

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

A child of the covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the City of Urbandale during the covered employee's period of employment with the City of Urbandale is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

ASSISTANCE WITH QUESTIONS

Questions concerning the Plan or the participant's COBRA rights should be addressed to the contact or contacts identified below.

KEEP THE PLAN INFORMED OF ADDRESS CHANGES

In order to protect the participant family's rights, he/she should keep the Plan Administrator informed of any changes in the addresses of family members. The participant should also keep a copy, for his/her records, of any notices sent to the Plan Administrator or the Plan Administrator.

PLAN CONTACT INFORMATION

The participant may obtain information about the Plan and COBRA coverage on request from:

COBRA Specialist
Bernie Lowe & Associates, Inc.

1555 Delaware Ave., Suite A
Ankeny, IA 50021

800-942-4718 (Toll Free)

The contact information for the Plan may change from time to time. The most recent information will be included in the Plan's most recent Summary Plan Description (if the participant is not sure whether this is the Plan's most recent Summary Plan Description, he/she may request the most recent one from the Plan Administrator or the Plan Administrator).

INDIVIDUAL HEALTH COVERAGE PROVISION

If the state in which a qualified beneficiary resides does not offer adequate alternative mechanisms for providing access to health benefits for individuals, Federal law requires insurance companies that sell individual health insurance policies in the state where a qualified beneficiary resides to offer a beneficiary, whose continuation coverage is exhausted, the opportunity to purchase an individual health insurance policy from the insurer. The offer of individual health coverage need not be made if the participant is covered under another group health plan, Medicare or Medicaid, or by any other policy of health insurance.

A participant should contact:

Bernie Lowe & Associates, Inc.
1555 SE Delaware Ave., Suite A
Ankeny, IA 50021
800-942-4718

if he/she is interested in individual health coverage through this provision.

CREDITABLE COVERAGE PROVISION

Qualifying periods of time during which a participant had "creditable coverage" will be applied toward the satisfaction of the participant's pre-existing condition exclusion period. Prior carriers or employers will provide certification regarding a participant's prior coverage. In addition, the participant may request a certificate of creditable coverage under this Plan at any time from the Benefit Services Administrator or the Plan Administrator up to 24 months after the participant's coverage ceases. This certification will be used to determine what portion of the participant's pre-existing condition exclusion period, if any, must still be satisfied.

Written requests for Certificates must include:

- the name of the individual for whom the Certificate is requested;
- the last date that the individual was covered under the Plan;
- the name of the participant that enrolled the individual in the Plan;
- a telephone number to reach the individual for whom the Certificate is requested, in the event of any difficulties;
- the name of the person making the request and evidence of that person's authority to request and receive the Certificate on behalf of the individual;
- the address to which the Certificate should be mailed; and
- the requestor's signature.

After receiving a request that meets these requirements, the Plan will act in a reasonable and prompt fashion to provide the Certificate.

Prior coverage does not qualify under this provision if there is a break in coverage of 63-consecutive days or more. Waiting periods are not considered periods without coverage nor are they counted as creditable coverage. Refer to the **Definitions** section for a definition of "Creditable Coverage".

As required by the Trade Act of 2002, the days between the date an individual loses group health coverage and the first day of the second TAA/ATAA-related COBRA election period are not taken into account in determining whether a significant break in coverage has occurred, even though COBRA coverage elected during the second election period is not retroactive to the date of the initial loss of coverage.

PRE-EXISTING CONDITION EXCLUSION PERIOD

This Plan includes an exclusion period for new participants with pre-existing (not otherwise excludable) medical conditions. A pre-existing medical condition is an injury or illness which was present prior to the participant's date of enrollment (see definition) for which any medical advice, diagnosis, care or treatment (including having a prescription for legend drugs, whether or not the drugs are taken) was provided or recommended by a physician prior to the participant's date of enrollment. Genetic information is not treated as a

pre-existing condition in the absence of a diagnosis of a condition related to the genetic information. This pre-existing condition exclusion period will not be applied to any participant or dependent under age 19 and never applies to pregnancy, regardless of whether the woman had previous coverage.

The pre-existing condition exclusion period works as follows:

If a participant has a pre-existing, allowable medical condition (physical or mental) within the 90-day period prior to his/her date of enrollment for medical coverage (this 90-day period is called the look-back period), that allowable condition will not be covered under this Plan until 12 months following the participant's date of enrollment.

The 12-month pre-existing condition exclusion period will be reduced by the length of the aggregate period of any creditable prior coverage.

This Plan will apply the standard method of counting creditable coverage. The standard method of counting creditable coverage determines an individual's creditable coverage without reference to specific benefits provided during the individual's prior coverage periods.

Charges incurred during the 12-month pre-existing condition exclusion period will be reviewed by the Benefit Services Administrator and allowable conditions which appear to be pre-existing will be investigated.

Benefits will be available for all covered services with the exception of the allowable condition(s) specifically identified as being pre-existing.

All pre-existing condition exclusion periods (and accompanying 90-day look-back periods) for *special enrollees* begin on the participant or dependent's effective date. Pre-existing condition exclusion periods (and accompanying 90-day look-back periods) for *new hires* will begin on the date the participant enters a class eligible for coverage.

PRE-TAX PREMIUM PROGRAM

The pre-tax premium program allows the employee to purchase this Plan with pre-tax dollars. Under the pre-tax premium program, the money that the employee would normally have deducted on an after-tax basis would instead be deducted on a pre-tax basis through salary redirection. The advantage of the pre-tax premium

program is that the employee pays no FICA (Social Security) taxes or federal income taxes on the pre-tax premium contributions he/she makes. Furthermore, the premium is also exempt from state income taxes in most states. This means a higher take-home pay for the employee, than if he/she purchased this Plan with after-tax dollars.

Note: Because the premium contributions the employee makes to this Plan are not taxed as wages for Social Security purposes, the employee's ultimate Social Security benefits might be somewhat less than they could have been. This depends on many things, including the employee's earnings history, whether he/she is above or below the Social Security "wage base," and what happens to the Social Security laws between now and when he/she retires.

The pre-tax premium program is available to the employee if he/she meets the eligibility requirements under this Plan. The employee's premium will automatically be deducted from his/her paycheck on a pre-tax basis. If the employee wishes to pay his/her premiums on an after-tax basis, he/she must notify Human Resources.

The employee's enrollment regarding the tax status of premiums will continue in effect until the employee changes it. The employee can make this change only during the period prior to the start of each Plan Year as designated by the Plan Administrator or if he/she experiences a change in family status, as defined by the Internal Revenue Service.

The employee's choices are in effect for the entire Plan Year. Only under special circumstances, such as changes in family status including, but not limited to: marriage, divorce, legal separation death of a spouse or child, birth or adoption of a child, the termination or commencement of a spouse's employment, a significant increase in the employee's costs with respect to this Plan, the switching from part-time to full-time employment status, or the reverse, by the employee or spouse or the taking of an unpaid leave of absence by the employee or spouse - would allow an employee to change his/her selected benefits. The change must be consistent with the family status change, to the extent that it is necessary or appropriate, as a result of the family status change.

OTHER HEALTH PLAN FACTS

ASSIGNMENT OF BENEFITS

In PPO Area

Because of a contractual agreement with SelectFirstTM, benefits will be automatically assigned to participating providers. This Plan will not honor assignment of benefits received for any non-participating physicians or facilities. These benefits will be sent directly to the participant. Providers who do not participate in this network will not have benefits directly assigned to them. It is the participant's responsibility to make full payment to a non-participating provider.

Out-of-Area

This Plan accepts all assignments of benefits to make direct payments to providers of benefits, including, but not limited to, physicians, hospitals, and nursing facilities.

In General

Unless applicable law otherwise requires, no amount payable at any time will be subject in any manner to alienation by anticipation, sale, transfer, assignment, bankruptcy, pledge, attachment, charge or encumbrance of any kind and any attempt to alienate, sell, transfer, assign, pledge, attach, charge or otherwise encumber any amount, whether presently or at a later date payable, will be void. This Plan will not be liable for, or subject to, the debts or liabilities of any person entitled to any amount payable under this Plan. If by reason of the bankruptcy or other event happening at any such time such amount would not be enjoyed by them, then the Plan Administrator in its sole discretion, may terminate his/her interest in any such amount and will hold or apply it to or for the benefit of the participant, his/her spouse, children or other dependents, or any of them, in such manner as the Plan Administrator may deem proper.

FILING OF CLAIMS

SelectFirstTM Physician Billings

SelectFirstTM physicians agree to submit claims for all covered services provided to SelectFirstTM participants.

SelectFirstTM Participating Hospital Billings

Participating hospitals are required to submit billings for covered services provided to SelectFirstTM participants.

All Other Providers

Claims must be received within one year of the day charges are incurred to be eligible for benefits. The provider may submit billing statements on behalf of the participant, but it is the participant's responsibility to make sure claims are filed within this time.

All claims must be mailed to:

First Administrators, Inc.
Claims Department
P.O. Box 9900
Sioux City, Iowa 51102

In General

Each participant shall file with the Benefit Services Administrator any pertinent information concerning himself/herself as the Benefit Services Administrator (or the Plan Administrator) may specify and in the manner and form as the Benefit Services Administrator (or the Plan Administrator) may specify or provide. The participant will not have any rights or be entitled to any benefits or further benefits hereunder, as the case may be, unless the information requested is filed by him/her or on his/her behalf. Each participant claiming benefits under the Plan shall supply written proof that covered expenses were incurred or that the benefit is covered under this Plan. If the Benefit Services Administrator determines that a participant has not incurred a covered expense or that the benefit is not covered under this Plan, or if the participant fails to furnish the proof requested, no benefits or no further benefits will be payable to the participant.

NOTIFICATION OF DECISION

Notice of a decision by the Benefit Services Administrator regarding a claim will be furnished to the claimant within 30 days following the receipt of the claim (or within 30 days following the expiration of the initial 30-day period, in a case where there are special circumstances requiring extension of time for processing the claim). If special circumstances require an extension of time for processing the claim, written notice of the extension will be furnished to the participant prior to the expiration of the initial 30-day period. The notice of extension will indicate the special circumstances requiring

extension and the date by which the notice of decision with respect to the claim will be furnished. Commencement of benefit payments will constitute notice of approval of a claim to the extent of the approved amount.

If the claim will be wholly or partially denied, the notice will describe:

- a) the specific reason or reasons for the denial;
- b) specific reference to pertinent provisions of this Plan on which the denial is based;
- c) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and
- d) an explanation of this Plan's claims review procedure.

If the Benefit Services Administrator fails to notify the claimant of the decision regarding his/her claim in accordance with this provision, the claim will be deemed denied and the claimant will then be permitted to proceed with the claims review procedure provided in the following section.

CLAIMS REVIEW PROCEDURE

The purpose of the review procedure is to provide a procedure by which a participant, under this Plan, may have reasonable opportunity to appeal a denial of a claim to an appropriate named fiduciary for a full and fair review.

To accomplish that purpose, the participant or his duly authorized representative may:

- (a) request review hereunder upon written application;
- (b) review pertinent documents; and
- (c) submit issues and comments in writing.

Within 180 days following receipt by the claimant of notice of the claim denial, or within 180 days following the close of the 30-day period referred to in the Notification of Decision provision, if the Benefit Services Administrator fails to notify the claimant of the decision within the 30-day period, the claimant may appeal denial of the claim by filing a written application for review with the Plan Administrator. Following the request for review, the Plan Administrator will fully and fairly review the decision denying the claim.

Prior to the decision of the Plan Administrator, the claimant will be given an opportunity to review pertinent documents and to submit issues and comments in writing and request a review by the Plan Administrator of a decision denying the claim. The request will be made in writing, requesting a review by the Plan Administrator denying the claim, and filed with the Benefit Services Administrator within 180 days after delivery to the claimant of written notice of the decision. The written request for review will contain all additional information which the claimant wishes the Plan Administrator to consider. The Plan Administrator may hold a hearing or conduct an independent investigation regarding the merits of the denied claim promptly. Within 60 days following receipt by the Benefit Services Administrator of the request for review of a denied claim (or within 240 days after the receipt of the original written notice), the Benefit Services Administrator, on behalf of the Plan Administrator, will deliver such decision, in writing, to the claimant. In cases where there are special circumstances requiring an extension of time for reviewing the denied claim, the Benefit Services Administrator, on behalf of the Plan Administrator, will also deliver that decision, in writing, to the claimant. If the decision on review is not furnished within the prescribed time, the claim will be deemed denied on review.

For all purposes under this Plan, the decision on claims will be final, binding, and conclusive on all interested parties as to participation relating to this Plan.

External Review

If the appeal process has been exhausted regarding a denial of benefits based on medical necessity, the participant or his/her provider, acting on the participant's behalf, may be entitled to request an external review of the Plan Administrator's decision through the Iowa Commissioner of Insurance. Requests must be filed in writing at the following address, no later than 60 days following the Plan Administrator's decision.

Iowa Division of Insurance
330 Maple Street
Des Moines, Iowa 50319-0065
Fax: 1-515-281-3059
Telephone: 1-515-281-5705

COORDINATION OF BENEFITS

Note: If both employee and spouse work and are covered under the City's Plan, coordination of benefits **will not apply**.

Coordination of Benefits (COB) refers to a process that is utilized when the participant or family member has other insurance or coverage that provides the same or similar benefits as this Plan. The benefits payable under this Plan, when combined with the benefits paid under other coverage, will not be more than 100% of either this Plan's payment arrangement amount or the other carrier's payment arrangement amount.

This Plan, utilizing its normal benefit calculation method, will determine the amount to be paid and then subtract the payment(s) made by plans determined to be primary. The sum of all payments will never exceed the actual charge.

When services are received, the participant must notify the Benefit Services Administrator that he/she has other coverage. Other coverage includes: group insurance; other group benefit Plans (e.g., HMOs, PPOs, and self-insured programs); Medicare or other governmental benefits; and the medical benefits coverage in the participant's automobile insurance (whether issued on a fault or no fault basis). To help the Benefit Services Administrator coordinate benefits, the participant shall:

- inform the provider by giving him/her information about the other coverage at the time services are received. The provider will pass the information on to the Benefit Services Administrator when the claim is filed; and
- indicate there is other coverage when filling out a claim form by completing the appropriate boxes on the form. The participant will receive a letter from the Benefit Services Administrator if any additional information is needed.

It is important that the participant provides the Benefit Services Administrator with the requested information concerning other coverage. If the participant does not provide the necessary information, claims will be denied.

The following guidelines will be used to determine which plan will be primary:

- (a) If one plan has a COB provision and the other does not, the plan without a COB will be primary.

- (b) The medical benefits of the participant's auto coverage will pay before this Plan if the auto coverage does not contain a coordination of benefits provision that specifies it is secondary or excess to health insurance or health benefit plans.
- (c) If both plans have a COB clause, the plan covering the participant as an employee will be primary over the plan covering the participant as a dependent.
- (d) If the participant is the main person covered under both plans (the participant is not a dependent under either plan), the plan that has provided coverage the longest will be primary.
- (e) The plan covering the participant as an active participant will pay before the plan covering an inactive participant. Participants in retiree plans, COBRA or other similar continuation coverage are considered inactive participants.
- (f) For a dependent child, the primary plan is the plan of the parent whose birthday (excluding year of birth) occurs earlier in the calendar year. For example: if the father's birthday is June 1 and the mother's birthday is May 1, the mother's plan would be primary for the children.
- (g) If both parents have the same birth month and day, the plan which has been in effect longest would be primary.
- (h) When the parents of a dependent child are divorced or separated and the parent with custody has not remarried, that parent's plan is primary for the child. The plan of the parent without custody pays second. When the parent with custody has remarried, that parent's plan pays is primary, the stepparent's plan is secondary and the plan of the parent without custody pays will be coverage of last resort. If there is a court decree which stipulates which parent has financial responsibility for the medical bills for the dependent child, the benefits of that parent's plan will be determined before the benefits of any other plans which cover the child as a dependent.
- (i) If none of the above rules determines the order of benefits, the plan which has covered an insured person is determined first.

SelectFirst™

If this Plan is the secondary payor, and the provider is a SelectFirst™ participating provider, the billed charges will be subject to the SelectFirst™ fee schedule or discount. This Plan's payments as secondary payor, combined with the primary payor's payment, will never exceed the allowable payment according to the SelectFirst™ fee schedule or discount arrangement.

COORDINATION WITH MEDICARE

If the participant is an active employee age 65 or older, this Plan will be primary over Medicare Part A, B, and D. Medicare will then be secondary to this Plan.

If the employer's health Plan is rejected, Medicare will remain the primary health insurance payer. If this Plan is elected, Medicare becomes the secondary payer for employees and spouses age 65 and over.

MEDICARE AS SECONDARY PAYOR

Since 1980, Congress has passed legislation making Medicare the secondary payor and group health plans the primary payor in a variety of situations. These laws apply only if the participant has both Medicare and health coverage under this Plan and this Plan has the minimum required number of employees as described in the following paragraphs.

Working Aged

This provision applies only to group health Plans of employers with at least 20 employees for each working day for at least 20 calendar weeks in the current or preceding year. Under this provision, Medicare is the secondary payor if the beneficiary is both of the following:

- Age 65 or older.
- A current employee or spouse of a current employee covered by an employer group health plan.

Working Disabled

This provision applies only to group health plans of employers that had at least 100 full-time, part-time, or leased employees on at least 50% of the regular business days during the preceding calendar year. Under this provision, Medicare is the secondary payer if the beneficiary is all of the following:

- Under age 65.

- A recipient of Medicare disability benefits.
- A current employee, or a spouse or dependent of a current employee, covered by an employer group health plan.

End-Stage Renal Disease (ESRD)

The ESRD requirements apply to group health plans of all employers, regardless of the number of employees. Under these provisions, Medicare is the secondary payor during the first 30 months of Medicare coverage if both of the following are true:

- The beneficiary has Medicare coverage as an ESRD patient.
- The beneficiary is covered by an employer group health plan.

If the beneficiary is already covered by Medicare due to age or disability and becomes eligible for Medicare ESRD coverage, Medicare generally is the secondary payor during the first 30 months of ESRD eligibility. However, if the group health plan is secondary to Medicare (based on other Medicare secondary payor requirements) at the time the beneficiary becomes covered for ESRD, the group plan remains secondary to Medicare.

The above provisions are a general summary of the laws, which may change from time to time. For more information, contact the employer or the Social Security Administration.

MEDICARE AS PRIMARY PAYOR

When the foregoing subsection "Medicare as Secondary Payor" does not apply, benefits otherwise payable under this Plan for allowable expenses shall be reduced so that the sum of benefits payable under this Plan and Medicare shall not exceed the total of such allowable expense.

Benefits shall be payable under this Plan after Medicare benefits have been paid whether or not such participant is disabled and not in an active employment status and under or over age 65, other than as specified for an ESRD beneficiary in the foregoing subsection.

Benefits shall be considered payable by Medicare for purposes of this section when the participant is eligible for Medicare benefits.

Benefits could be reduced if the participant:

- has not enrolled or applied for benefits under Medicare;

- has failed to take any action required by Medicare to qualify for benefits; or
- received benefits payable by Medicare if services were received in a facility to which Medicare would have paid.

In the event a participant enters into a private contract with a Physician in accordance with Medicare private contracting arrangements, this Plan shall not coordinate benefits or assume a primary payor position on any such participant.

RELEASE OF INFORMATION

The Benefit Services Administrator may, without notice to or consent of the covered person, release to or obtain from any insurance company or other organization or person any information regarding coverage, expenses, and benefits which the Benefit Services Administrator, at its sole discretion, considers necessary to apply the provisions of this Plan.

RIGHT OF RECOVERY

Whenever benefits have been paid in excess of the minimum amount necessary to satisfy the intent of the Coordination of Benefits provision (***established so a covered person cannot profit from this Plan***), the Plan Administrator will have the right to recover those payments to the extent of the excess amount from any one or more of the following as the Plan Administrator determines:

- any persons to whom such payments were made; or
- any insurance companies or any other organizations.

The Plan Administrator will also have the right to make the payment of any amounts it determines to be warranted to satisfy the intent of the Coordination of Benefits provision of this Plan. These payments will be made to any organizations making payments under other plans which should have been made under this Plan.

THIRD PARTY REIMBURSEMENT

If benefits have been paid or are payable under this Plan for services received by a participant, and it is later established that the charges for these services were not paid or are not payable by the participant or that the participant was otherwise reimbursed or may be reimbursed, except by insurers of policies of health insurance issued to the participant as an individual, this Plan will be entitled to a refund of the amount of the benefits paid which are in excess of

the benefits that would have been payable based on the actual charges incurred and paid.

SUBROGATION

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of medical benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons, plan beneficiaries, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, where other insurance is available, including but not limited to no-fault, uninsured motorist, underinsured motorist, and medical payment provisions (collectively "Coverage").

Covered Person(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Covered Person(s) agrees the Plan shall have an equitable lien on any funds received by the Covered Person(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.

In the event a Covered Person(s) settles, recovers, or is reimbursed by any third party or Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s). If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Covered Person(s) agrees to subrogate the Plan to any and all claims, causes of action or rights that may arise

against any person, corporation and/or entity and to any Coverage to which the Covered Person(s) is entitled, regardless of how classified or characterized.

If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable subrogation lien attaches in favor of the Plan to any claim, which any Covered Person(s) may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

The Plan may in its own name or in the name of the Covered Person(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Covered Person(s) fails to file a claim or pursue damages against:

- the responsible party, its insurer, or any other source on behalf of that party;
- any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- any policy of insurance from any insurance company or guarantor of a third party;
- worker's compensation or other liability insurance company; or,
- any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverages;

the Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether

the Covered Person(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable subrogation lien. The obligation exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Person(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

Excess Insurance

If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as provided for under the Plan's Coordination of Benefits section. The Plan's benefits shall be excess to:

- the responsible party, its insurer, or any other source on behalf of that party;

- any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- any policy of insurance from any insurance company or guarantor of a third party;
- worker's compensation or other liability insurance company; or
- any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person(s), or filing of bankruptcy by the Covered Person(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and

Wrongful Death

In the event that the Covered Person(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

Obligations

It is the Covered Person(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:

- to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
- to provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
- to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;

- to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
- to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
- to not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person(s) may have against any responsible party or Coverage.

If the Covered Person(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Person(s)' cooperation or adherence to these terms.

Offset

Failure by the Covered Person(s) and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld until the Covered Person(s) satisfies his or her obligation.

Minor Status

In the event the Covered Person(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this

provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

WORKERS' COMPENSATION

This Plan is not meant to be a substitute for workers' compensation. Any benefits paid by this Plan which are determined to be the liability of any workers' compensation plan of benefits will be refunded to this Plan by the participant and/or his/her heirs or estate. Any participant hereby agrees to reimburse this Plan for any payments so made under this Plan out of any monies recovered from any workers' compensation plan as the result of judgment, settlement or otherwise, and the participant does agree to take such action, to furnish such information and assistance, and to execute and deliver all necessary instruments as the Plan Administrator may require to facilitate the enforcement of this Plan's rights and not to prejudice those rights. Any portion of any settlement that is agreed upon which is for future expenses will also be recoverable under this Plan, as those expenses occur.

OVERPAYMENT OF CLAIMS

Each participant hereby authorizes the deduction of any excess benefit received or benefits which should not have been paid, from any present or future compensation payments.

CONFORMITY WITH LAW

This Plan shall be governed by the laws of the state of Iowa. If any provision of this Plan is contrary to any law to which it is subject, or if a law relevant to this Plan is not specifically addressed within the contents of pertinent documents, such provision will be amended to satisfy the law's minimum requirement.

NOTICE OF LOSS

If the employer does not fund this Plan, the employee, as the covered participant, may be

held responsible for any incurred and unpaid claims.

DEFINITIONS

"**ACTIVELY AT WORK**" means the performance of all the duties that pertain to the participant's work at his/her normal place of employment, or any other location required by the employer.

"**ACTIVE DUTY**" means full-time duty in the active military service of the United States. Such term includes full-time training duty, annual training duty, and attendance, while in the active military service, at a school designated as a service school by law or by the Secretary of the military department concerned. Such term does not include full-time National Guard duty.

"**ADOPTED CHILD(REN)**" means any child legally placed in an employee's home by an adoption agency who meets the eligibility requirements of this Plan, whether or not the adoption is final. Placement is defined as the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of such child.

"**ALCOHOLISM**" means a chronic disease characterized by the use of alcoholic beverages to the extent that it interferes with the covered person's health, social, family, or economic functioning.

"**ALLOWABLE EXPENSES**" mean the portion of an eligible expense actually payable by this Plan, after taking into account co-pay, deductible, and coinsurance amounts, any applicable benefit maximum or maximums, and any other limitation or exclusion provided for under this Plan.

"**ALTERNATE RECIPIENT**" means any child of a participant who is recognized under a Qualified Medical Child Support Order (QMCSO) as having a right to enrollment in the Plan with respect to such participant.

"**AMBULATORY SURGERY CENTER**" is any public or private establishment with an organized medical staff of physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing outpatient surgical procedures. Continuous physician and registered professional nursing services must be available whenever a patient is in the facility. An ambulatory surgery center does not provide services or other accommodations for patients to stay overnight.

"**AMENDMENT**" means a formal document that changes a provision of this Plan, duly signed by the authorized person or persons as designated by the City.

"**BENEFITS**" means those medically necessary services and supplies that qualify for payment under this Plan.

"**BENEFIT SERVICES ADMINISTRATOR**" means First Administrators, Inc., an Iowa corporation.

"**BIOLOGICALLY BASED MENTAL ILLNESSES**" means schizophrenia, schizoaffective disorders, major depressive disorders, bipolar disorder, pervasive developmental disorders, obsessive-compulsive disorders, and autistic disorder, as these terms are defined in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American Psychiatric Association.

"**BIRTHING CENTER**" is a facility providing care for pregnant women through the services of a nurse midwife. A nurse midwife provides obstetric services with an obstetrician on 24-hour medical backup in case of complications.

"**BUSINESS ASSOCIATE**" means a person or organization that performs a function or activity on behalf of a covered entity, but is not part of the covered entity's workforce. A business associate can also be a covered entity in its own right. (Also see Part II, 45 Code of Federal Regulations Part 160.103).

"**CALENDAR YEAR**" means the 12-month period commencing January 1 and ending the following December 31.

"**CHEMICAL DEPENDENCY**" means any condition resulting from dependency on or abuse of a psychoactive substance as described in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition – Revised*, (DSM-IV-R), published by the American Psychiatric Association or subsequent revisions to DSM-IV-R.

"**CHEMICAL DEPENDENCY FACILITY**" means a licensed free-standing facility approved by this Plan to provide treatment for chemical dependency conditions.

"**CHILD(REN)**" means child(ren) of a covered employee, including natural children, adopted children, stepchildren and any other child for whom the employee has legal guardianship or for a child for whom the employee had noted legal guardianship on the child's 18th birthday (proof is required)..

"**COINSURANCE**" means the percentage of eligible expenses allocable to the participant and the employer after any applicable co-pays, calendar year deductibles, and non-compliance penalties have been applied.

"COMMUNITY MENTAL HEALTH CENTER" means a facility established for the purpose of providing consultation, diagnosis, and treatment in connection with a mental health disorder, and approved as such by a state department or agency having authority over such facilities.

"CONTINGENCY OPERATION" means designated by the Secretary of Defense as an operation in which members of the Armed Forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force.

"COVERED DEPENDENT" means a spouse or a dependent child who has satisfied the definition of dependent and the eligibility requirements specified in this Plan.

"COVERED EMPLOYEE" means any employee who is eligible, and enrolled, for benefits specified in this Plan.

"COVERED EXPENSES" mean those expenses covered by this Plan, including the hospital, surgical, and medical care expenses described in this booklet. A covered expense does not include any expense expressly excluded from coverage under this Plan. Thus, for example, but not by way of limitation, a covered expense does not include an expense which is listed as a type of expense otherwise covered under this Plan, but which is not medically necessary, or which is experimental or investigational in nature, nor does it include the *portion* of an otherwise covered expense which exceeds the maximum amount considered by this Plan for the service or supply. See also the definitions of eligible expenses and allowable expenses.

"COVERED SERVICEMEMBER" means a member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness. Also included is a veteran who is undergoing medical treatment, recuperation, or therapy, for a serious injury or illness and who was a member of the Armed Forces (including a member of the National Guard or Reserves) at any time during the period of five years preceding the date on which the veteran undergoes that medical treatment, recuperation, or therapy.

"CREDITABLE COVERAGE" means coverage under a group health plan (including a governmental or church plan), health insurance coverage (either group or individual coverage, including COBRA continuation coverage, or

short-term "bridge" policy), Medicare, Medicaid, military-sponsored health care, a program of the Indian Health Service, a state health benefit risk pool, the Federal Employees Health Benefits Plan (FEHBP), a public health plan as defined in subsequent Centers for Medicare and Medicaid Services regulations, state Children's Health Insurance Program (S-Chip), public health plans provided by a foreign country or a political subdivision, and any health benefit plan under Peace Corps Act 5(e). "Creditable Coverage" does **not** include accident or disability income, liability, workers' compensation, automobile medical insurance, health coverage for limited benefits, such as limited scope dental or vision benefits or long-term care plans, or plans under which health benefits are secondary or incidental.

"CUSTODIAL CARE" helps with daily living activities. This type of care does not require the continuing attention and assistance of licensed medical or trained paramedical personnel. Some examples of custodial care are assistance in walking and getting in and out of bed; aid in bathing, dressing, feeding and other forms of assistance with normal bodily functions, preparation of special diets; and supervision of medication which usually can be self-administered. Custodial care is not a benefit under this Plan except as found in the Hospice benefit.

"DEDUCTIBLE" is the amount the covered person pays before payment of benefits by the Plan begins.

"DEPENDENT" means the spouse of an employee including a common law spouse and same-sex marriage partner and children of an employee.

"DISABLED" means the temporary inability of a covered employee to perform each and every regular duty pertaining to his/her occupation or employment for compensation or profit, or the temporary inability of a covered dependent to engage in the normal activities of a person in good health of like age and gender.

"DOMICILIARY CARE" means inpatient institutional care provided to the participant not because it is medically necessary, but because care in the home setting is not available, is unsuitable, or members of the patient's family are unwilling to provide care. Institutionalization because of abandonment constitutes domiciliary care. Domiciliary care is not a benefit under this Plan. Some examples of domiciliary care for which benefits are not payable:

- home care is not available, such as where institutionalization is primarily because parents work or where a hospital stay is extended beyond what is medically necessary because the patient lives alone;
- home care is not suitable, such as where a child is institutionalized because a parent(s) is an alcoholic who is not responsible enough to care for the child or because someone in the home has a contagious disease; or
- the family is unwilling to care for a person in the home, such as where a family does not want to handle a child who is difficult to manage.

"DRUG ABUSE" means a behavioral pattern of compulsive drug use characterized by an overwhelming involvement with a drug or drugs. This includes the securing of its supply by any means, a tendency to increase dosage over a period of a psychological and usually physical dependence on its effects. The condition often includes a deterioration of a covered person's health, accompanied by interference with the social, family, or economic functioning of the covered person as well as a high tendency to relapse after withdrawal.

"DURABLE MEDICAL EQUIPMENT" means medical equipment not otherwise excluded, which is designed for repeated use, is primarily and customarily used to serve a medical purpose, and is not useful to a person in the absence of an injury or illness. For the purpose of determining whether a piece of equipment constitutes durable medical equipment for coverage under this Plan, First Administrators, Inc. may consult the equipment list compiled from time to time for use in the administration of the Medicare program. Examples of durable medical equipment include, but are not limited to, wheelchairs, hospital beds, and respirators. Air conditioners, humidifiers, dehumidifiers, air purifiers, and other similar convenience items are not considered durable medical equipment.

"EFFECTIVE DATE" means the first day that benefits under this Plan would be in effect, after satisfaction of the waiting period, if applicable, and any other provisions or limitations contained herein.

"ELECTIVE SURGICAL PROCEDURE" means a non-emergency surgery that can be scheduled at any time without risking the patient's life or risking serious impairment to the patient's bodily functions.

"ELIGIBLE EXPENSE" means the portion of a covered expense which is considered for payment under this Plan. Where a participant incurs a covered expense for treatment of a condition, the treatment of which is normally covered by this Plan, but the course or manner of treatment of such condition is excluded from coverage because it is expressly so excluded, is not medically necessary, or is experimental, investigational, or otherwise not considered efficacious by the Plan Administrator for treatment of the condition, or because of any reason described in this Plan, the expense incurred for such course or manner of treatment is not an eligible expense. See the definition of allowable expense for a description of how this Plan computes the portion of an eligible expense which it will pay.

"EMERGENCY" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain that a prudent layperson, possessing an average knowledge of health and medicine, could reasonably expect absence of immediate medical attention to result in one of the following:

- Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy.
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

"EMPLOYEE" means any individual who is employed by the City.

"ENROLLMENT DATE" or **"DATE OF ENROLLMENT"** means the first day of the participant's waiting period under this Plan (typically, the date the participant's employment begins). The enrollment date for anyone who enrolls during a special enrollment period is the first day of coverage under this Plan.

"EXPERIMENTAL OR INVESTIGATIONAL SERVICES OR SUPPLIES" mean that one or more of the following is true:

- the device, drug or medicine cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the device, drug or medicine is furnished;
- the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure was reviewed and

approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval, and furthermore, that the treating facility's Institutional Review Board is reviewing such drug, device, treatment or procedure as being experimental or investigational;

- reliable evidence shows that the treatment, procedure, device, drug or medicine is the subject of ongoing phase I, II or III clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; and/or
- reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same treatment, procedure, device, drug or medicine; or the written informed consent used by the treating facility or by another facility studying substantially the same treatment, procedure, device, drug or medicine.

In addition, no reimbursement is available for payments of any: (1) treatments, services or supplies that are educational or provided primarily for research; or (2) treatments, procedures, devices, drugs or medicines or other expense relating to transplants of nonhuman organs.

"FEE SCHEDULE" means a contractually specified amount payable for physician's services within the PPO area.

"FISCAL PLAN YEAR" means the 12-consecutive month period commencing on August 1 and ending on the next following July 31.

"FULL-TIME STUDENT" means a covered dependent who is enrolled in a full-time (as defined by the institution they are attending) course of study in an approved institution of higher learning.

"HIPAA" means the Health Insurance Portability and Accountability Act, a Federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA gives Health and Human Services (HHS) the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payors (or plans) and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. (Also known as the Kennedy-Kassebaum Bill, the Kassebaum-Kennedy Bill, K2, or Public Law 104-191).

"HOME HEALTH CARE" means services provided by a home health agency. A Home Health Care Agency is a public or private agency or organization, or a subdivision thereof that is primarily engaged in providing skilled nursing and other therapeutic services. Policies are established by associated professional personnel including one or more physicians and one or more registered nurses to govern the services provided under the supervision of such a physician or nurse. The agency maintains clinical records on all patients. In cases where state and local law provides for the licensing of agencies or organizations of this nature, the agency must be licensed or approved by the state or local law as meeting the standards established for such licensing. Home Health Care Agency does not include an agency that is engaged primarily in the care and treatment of mental disease.

"HOSPITAL" means a legally constituted and operated institution having on the premises organized facilities, including organized diagnostic and surgical facilities, for the care and treatment of sick and injured persons. The care must be by or under the supervision of a staff of physicians with a registered nurse on duty or on call at all times. Any institution, or part thereof, used principally as a rest or nursing facility, a facility for the aged, chronically ill or convalescent, or facility providing primarily custodial or educational care is not considered a hospital.

"INFERTILITY" means the inability or diminished ability to produce offspring.

"ILLNESS" means a bodily disorder, bodily injury, disease or mental health condition

including pregnancy and complications of pregnancy.

"IMMEDIATE FAMILY" means a participant's legal spouse, parents, children, grandparents and siblings (brothers and/or sisters). This includes such persons whether related by blood or marriage (in-laws).

"IMMUNIZATION" is an injection with a specific antigen to promote antibody formation to make a person immune to a disease or less susceptible to a contagious disease.

"IMPACTED TOOTH" means a tooth that is positioned or wedged against another tooth, or covered by bone or soft tissue, so that it cannot erupt.

"INJURY" means a physical condition which is the result of an accident caused by an external force and occurring while this Plan is in effect, with respect to that participant, and which results in loss covered by this Plan; or a condition caused as the result of a incident which is precipitated by an act of unusual circumstances likely to result in unexpected consequences; the condition must be an instantaneous one, rather than one which continues, progresses or develops.

"INPATIENT" means a participant who is confined in a hospital or a nursing facility as a resident patient and subject to at least one day's room and board by the hospital or nursing facility.

"INTENSIVE CARE" means a unit exclusively reserved for critically and seriously ill or injured patients requiring constant audiovisual observation as prescribed by the attending physician which provides room and board, specialized registered nurse (RN) and other nursing care, and special equipment or supplies immediately available on a stand-by basis segregated from the rest of the hospital's facilities.

"LEGAL GUARDIAN" means a person recognized by a court of law as having the duty of taking care of and managing the property and rights of such person.

"LICENSED PRACTICAL NURSE" means an individual who has received specialized nursing training and practical nursing experience and who licensed to perform nursing services by the state in which he/she performs such services, other than one who ordinarily resides in the participant's home or who is a member of the participant's immediate family.

"LICENSED PUBLIC HEALTH NURSE" means a professional nurse who has the right to use the title registered nurse (RN), other than one who ordinarily resides in the patient's home or who is a member of the patient's immediate family, and who has extended their study in the public health field.

"LOCAL AIR AND GROUND AMBULANCE" means medically necessary transportation to an appropriate inpatient or outpatient facility in the surrounding area where the ambulance transportation originated. To determine if the ambulance transportation is covered, this Plan considers if no other method of transportation is appropriate, that the services necessary to treat the injury or illness are not available in the hospital, nursing facility in which the participant is an inpatient or outpatient and the point of destination is the nearest one with adequate and appropriate methods of care.

"MAXIMUM ALLOWABLE FEE" means the lesser of:

- The fee that has been negotiated with the provider whether directly or through one or more intermediaries, or shared savings contracts for the services; or
- The fee established by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographic area; or
- The billed charge for Out of Network Facility services.

"MEDICAL NECESSITY" means services and supplies provided are medically required and medically appropriate for diagnosis and treatment of the participant's condition, are consistent with professionally recognized standards of health care, and do not involve costs that are excessive in comparison with alternative services that would be effective for diagnosis and treatment of the participant's condition.

"MEDICARE" is the federal government's health insurance program established under Title XVIII of the Social Security Act for people age 65 and older and people of any age entitled to monthly disability benefits under the Social Security or Railroad Retirement Program. It is also available for those with chronic renal disease who require hemodialysis or kidney transplant.

"MENTAL HEALTH DISORDER" means any disorder classified in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth*

Edition-Revised (DSM-IV-R), or subsequent revisions to DSM-IV-R, and includes behavioral or psychological conditions not attributable to a mental disorder that are the focus of professional attention or treatment, but only to the extent services for such conditions are otherwise considered to be benefits under this Plan.

"NEXT OF KIN" means the nearest blood relative of an individual.

"NON-PPO MEMBER" or "NON-PPO PROVIDER" means any health care provider who is not a contracting member of a preferred provider organization utilized by this Plan.

"NURSING FACILITY" provides continuous skilled nursing services as ordered and certified by the attending physician. A registered nurse (RN) must supervise services and supplies on a 24-hour basis. A nursing facility must also be licensed under the laws of the state in which it operates.

"OUT-OF-POCKET MAXIMUM" is a specified amount that must be paid for covered services, out of his/her pocket, in a calendar year. The participant's out-of-pocket maximum is satisfied as indicated on the benefit summary. Once the out-of-pocket maximum has been met, this Plan pays 100% of the allowable expenses.

"OUTPATIENT" means a participant who receives treatment at a hospital, clinic or dispensary but is not confined to continuous 24-hour hospitalized care.

"PARTICIPANT" means any covered employee and any covered dependent.

"PHYSICIAN" means a physician legally licensed to practice medicine and surgery. Physician also means any other legally licensed practitioner of the healing arts providing care within the scope of the individual's license, services covered under this program and for which benefits are required to be provided by law. Physician does not mean a resident physician, intern, or other individual in training.

"PLAN" means this City of Urbandale Employee Health Benefit Plan, as set forth herein and as from time to time amended which is administered by First Administrators, Inc., the Benefit Services Administrator.

"PLAN ADMINISTRATOR" means the person or persons appointed to administer this Plan, if any, otherwise, the City of Urbandale.

"PLAN SPONSOR" means an entity that sponsors a health plan. This can be an employer, a union or some other entity. (Also

see Part II, 45 Code of Federal Regulations Part 164.501).

"PPO AREA" means the area encompassing the contracted PPO providers

"PPO MEMBER" or "PPO PROVIDER" means a contracted health care provider who is a member of a preferred provider organization utilized by this Plan.

"PRE-EXISTING CONDITION" means any limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that day.

"PREFERRED PROVIDER ORGANIZATION (PPO)" means an organization composed of a group of health care providers who have contracted to offer their services at a discount rate in accordance with the formal agreement between the City and the preferred provider organization.

"PROTECTED HEALTH INFORMATION (PHI)" means individually identifiable health information (any health information that can be tied back to an individual). (See Part II, 45 Code of Federal Regulations Part 164.501).

"PSYCHIATRIC MEDICAL INSTITUTION FOR CHILDREN (PMIC)" means a residential treatment facility licensed by the state of Iowa that provides long-term mental health treatment and services to children in residence who have been diagnosed with a biologically based mental illness.

"QUALIFIED BENEFICIARY" means a participant who qualifies for continuation of coverage under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as then constituted or later amended.

"QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)" means a judgment, decree or order (including judicially approved settlement agreements having the effect of an order) which provides for child support with respect to a child of a participant under the Employee Welfare Benefit Plan or provides health benefit coverage to such a child, and satisfies requirements set forth in this Plan. The QMCSO must be a judgment or decree issued by a court of competent jurisdiction or a state agency that administers child support enforcement programs.

"REGISTERED NURSE" means a professional nurse who has the right to use the title registered nurse (RN), other than one who ordinarily resides in the patient's home or who is a member of the patient's immediate family.

"REHABILITATION INSTITUTION" means a legally constituted and operated institution (other than a hospital) established to provide medical treatment for patients who require inpatient care for chemical dependency, but do not currently require continuous hospital services for such condition, and which has permanent facilities for inpatient medical care on the premises, including 24-hour nursing service under the supervision of a full-time registered nurse (RN), and maintains daily medical records on all patients. In no event will the term "rehabilitation institution" include any institution, or part thereof, which is used principally as a rest facility or nursing facility, facility for the aged, or one providing primarily custodial care.

"REINSURER" means the insurance company providing the excess risk insurance maintained by the City.

"ROOM AND BOARD" means all charges commonly made by a hospital for room and meals and for all general services and activities essential to the care of registered bed patients.

"SECOND SURGICAL OPINION" means a consultation with another physician which the Plan may allow to determine the appropriateness of a surgical procedure as the preferred course of treatment as recommended by the attending physician.

"SKILLED NURSING FACILITY" is an institution that furnishes room and board and skilled nursing services for medical care. The facility must provide one or more licensed nurses on duty at all times under the supervision, on a 24-hour basis, of a registered nurse or a physician.

"SPECIAL CARE UNIT" means a section, ward, or wing within the hospital which is separated from other hospital facilities and:

- is operated exclusively for the purpose of providing professional care and treatment for critical injuries or illnesses;
- has special supplies and equipment, necessary for such care and treatment, available on a standby basis for immediate use; and
- provides room and board and constant observation and care by a

registered nurse (RN) and other specially trained hospital personnel.

"SPOUSE" means a person to whom the participant is legally married, as defined by the laws of the state of the covered employee's residence. This will include common law spouses and same-sex marriage partners.

"STEPCHILD" means any biological or adopted child of the spouse of an employee.

"SURGICAL PROCEDURE" means cutting, suturing, treatment of burns, correction of fractures, reduction of dislocations, manipulation of joints under general anesthesia, electro-cauterization, tapping (paracentesis), application of plaster casts, administration of pneumothorax, endoscopy, the injection of sclerosing solutions, and obstetrical procedures.

"TERMINALLY ILL" means having a life expectancy of six months or less due to an illness from which the participant is not expected to recover. This is usually a chronic illness or condition for which there is no known cure.

"TOTAL DISABILITY" and "TOTALLY DISABLED" mean:

- In the case of the covered employee, due to illness or injury, he or she is wholly and continuously prevented from performing the normal duties of his or her regular occupation, including any occupation for which the employee is reasonably qualified by reason of education, training or experience;
- In the case of a covered dependent, due to illness or injury, he or she is wholly and continuously prevented from engaging in substantially all of the material activities of a person of the same gender and age who is in good health.

"VISIT" means each attendance of a physician or medical practitioner, including a registered nurse (RN), to the covered person, regardless of the type of professional services rendered during such attendance, whether it might be otherwise termed a "consultation", "treatment", or given some other name.

"WAITING PERIOD" means the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of the Plan can become effective.

"WELL-BABY CARE" and "WELL-CHILD CARE" mean pediatric preventive services appropriate to the age of a child from birth to age

two, and to include well-child care to age seven, as defined by current Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. Pediatric preventive services shall include, at minimum, a history and complete physical examination as well as developmental assessment, anticipatory guidance, immunizations, and laboratory

services including, but not limited to, screening for lead exposure as well as blood levels.

Group plans that provided coverage for pediatric vaccines as of May 1, 1993, may not reduce or eliminate this coverage. Failure to comply will result in an excise tax penalty equal to the penalty for plans that fail to provide COBRA coverage.

PLAN INFORMATION

Named Fiduciary/ Plan Sponsor:	City of Urbandale 3600 86 th Street Urbandale, Iowa 50322
Employer Identification #:	42-6004576
First Administrators Group Number:	78777
Fiscal Plan Year Ends:	July 31st
Participants:	All Full-Time and Permanent Part-Time Employees and Retirees
Plan Administrator and Agent for Legal Process of Plan:	City of Urbandale 3600 86 th Street Urbandale, Iowa 50322 (515) 278-3900
Plan Costs:	The Plan Sponsor and the employees pay the costs of the Plan.
Type of Benefits:	Health Benefits
Type of Administration:	Contract Administration
Third Party Administrator:	First Administrators, Inc. P.O. Box 8150 Rapid City, SD 57709
Authority to Amend Plan:	City Manager, City of Urbandale
Administration and Plan Administrator Authority:	<p>The Plan is administered through the local offices of the Plan Administrator to which the participant is associated. The Plan Administrator has retained the services of an Independent Benefit Services Administrator experienced in claims processing.</p> <p>The Plan is a legal entity. Legal notices may be filed with, and legal process served upon, the Benefit Services Administrator and Plan Administrator.</p> <p>The Plan Administrator has the full and final authority to decide all questions or controversies of whatever character arising in any manner between any parties or persons in connection with the Plan or the interpretation thereof, including the construction of the language of the Summary Plan Description, and any writing, decision, benefit eligibility and determination, instrument or accounts in connection with same and with the operation of this Plan or otherwise, which shall be binding upon all persons dealing with this Plan or claiming any benefits thereunder, except to the extent that the Plan Administrator may subsequently determine, in their sole discretion, that their original decision was in error or to the extent such decision may be determined to be arbitrary or capricious by a court or arbitrator having jurisdiction over such matters.</p>

If the employer is unable to fund this Plan, the participant may be financially responsible for any incurred and unpaid claims. The Benefit Services Administrator assumes no financial liability.

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