PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

FOR

CITY/COUNTY WRAP AND WELLNESS PLANS

CITY OF BURLINGTON, IOWA

DES MOINES COUNTY, IOWA
&
RELATED GOVERNMENTAL AGENCIES

EFFECTIVE JULY 1, 1983
AMENDED AND REVISED JULY 1, 2016

ADMINISTERED BY:

EMPLOYEE BENEFIT SYSTEMS
HELPING ADMINISTER YOUR SUCCESS

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

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GENERAL PLAN INFORMATION

Type of Administration

This document describes the City/County Health Care Plan for Self-Funded Wrap and Wellness Coverages.

Plan Name: City/County Health Care Plan for Self-Funded Wrap and Wellness

Tax I.D. Number: 47-3024022

Plan Effective Date: July 1, 1983

Plan Year Begins: July 1

Plan Year Ends: June 30

CLAIM INSTRUCTIONS

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

HOW TO FILE A WRAP CLAIM

Please attach your primary Explanation of Benefit (EOB) when filing for wrap benefits.

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

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

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

CLAIMS ADMINISTRATOR:

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

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

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

TO ALL ELIGIBLE EMPLOYEES:

Your group benefit program is designed to provide adequate protection and to meet the needs of the members and their dependents. This Plan is as comprehensive as possible, consistent with sound financial policy. To help you understand this coverage and how it will best service you, the following pages of this booklet describe some of the benefits available to you.

Participating Agencies

City of Burlington, Iowa

County of Des Moines, Iowa

Burlington Municipal Waterworks

Southeast Iowa Regional Airport Authority

Des Moines County Emergency Communications

Des Moines County Regional Solid Waste Commission

Two Rivers Levee and Drainage District Association

City of Mediapolis, Iowa

City of Danville, Iowa

ARTICLE I

USING THE PLAN BOOKLET

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

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

Wrap Plan: Your Benefits are described in Article III.

Wellness & Prevention: Your Benefits are described in Article IV.

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

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

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

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

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

ARTICLE II

WRAP PLAN ELIGIBILITY and SPECIAL ENROLLMENT

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

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

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

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

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

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

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

- your marriage;
- the birth, adoption, or placement for adoption of a child;
- your death or the death of your spouse or other eligible dependent;
- your divorce, annulment, or legal separation;
- a change in a dependent child's eligibility due to age or eligibility for other coverage;
- a change in employment status for you or your spouse that affects benefits (including termination or commencement of employment, strike or lockout, or commencement of or return from an unpaid leave of absence);
- a change in your Company work location or home address that changes your overall benefit options and/or prices;

- employee's spouse's open enrollment period differs and employee needs to make changes to account for other coverage;
- a significant change in coverage or the cost of coverage;
- a reduction or loss of your or a dependent's coverage under this or another plan;
- a court order, such as a QMCSO or NMSN, that mandates coverage for an eligible dependent child.

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

You should report a status change as soon as possible, but no later than 30 days, after the event occurs.

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

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

Duplicate Coverage: If both employee and spouse are employed by the same or different employers covered by this Plan, only one may carry the Wrap Plan family coverage on the entire family unit. A person may not be covered as both an Employee and as a Dependent.

ARTICLE III

WRAP PLAN

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

ARTICLE IV

WELLNESS & PREVENTION

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

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

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

HEALTH FITNESS PROGRAM

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

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

PERSONAL TRAINING

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

STRESS MANAGEMENT

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

SMOKELESS – GRMC Center for Rehab

This stop smoking program is a positive approach to breaking the smoking habit. The system uses stress management, positive rewards and reinforcements,

attitudinal transformation, food management, education, motivational tools and patented negative smoking techniques that will have you off cigarettes in 5 days. Best of all, Smokeless curbs withdrawal discomfort and irritability while it controls your weight.

SMOKING CESSATION MEDICATIONS

Patches, oral medications, gum.

AQUATIC AEROBICS

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

Specialized programs are:

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

YOGA

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

CARDIAC REHABILITATION PHASE III

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

FITNESS CENTERS

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

PUBLIC SWIMMING POOL PASSES

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

WEIGHT WATCHERS OR STRUCTURED WEIGHT REDUCTION PROGRAMS

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

PUBLIC GOLF COURSES

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

SPORTS REGISTRATIONS

League or team registration fees.
Registration fees for area runs/walks.

NUTRITIONAL COUNSELING

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

ZUMBA

Classes must be with a certified instructor.

KARATE

Classes must be with a certified instructor.

UNDER WEIGHT PROGRAMS

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

POLICE DEPARTMENT FITNESS EQUIPMENT

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

FIRE DEPARTMENT FITNESS EQUIPMENT

Employees may pool their available wellness dollars together towards the purchase of fitness equipment to be stored and used in the Fire Department fitness room. Once the equipment is purchased, the equipment becomes the property of the City. The equipment must remain on site, and be accessible to any City/County Healthcare Plan member for use. Those choosing to pool their wellness dollars together for this purchase will not be entitled to any refund or

reuse of that year's wellness benefit once the transaction is processed. This eligible expense is only available for equipment purchased for the Fire Department fitness room.

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

1. Personal exercise equipment
2. Clothing
3. Massage
4. Food
5. Dance Lessons
6. Routine Preventive Care that is covered under your medical plan

ARTICLE V

DEFINITIONS

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

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

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

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

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

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

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

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

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

- A natural child.
- Legally adopted or placed for adoption (that is, you assume a legal obligation to provide full or partial support and intend to adopt the child).
- A child for whom you have legal guardianship.
- A stepchild.
- A foster child.
- A natural child a court orders to be covered.
- A dependent child who has been placed in your home for the purpose of adoption or whom you have adopted is eligible for coverage on the date of placement for adoption or the date of actual adoption, whichever occurs first.

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

- Under 26 years of age; or
- Over 26 years of age, unmarried and a full-time student at an accredited institution of postsecondary education, such as a college, university, nursing school, or trade school and carry 12 or more hours per semester;

OR

- Totally Disabled and incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

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

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

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

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

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

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

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

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

"PLAN" means this City/County Health Care Plan, effective July 1, 1983 as amended.

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

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

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

ARTICLE VI

TERM AND TERMINATION

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

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

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

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

d) The date the Plan is terminated.

ARTICLE VII

YOUR HIPAA RIGHTS

Health Insurance Portability and Accountability Act (HIPAA)

Title II of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations at 45 CFR Parts 160 through 164 (HIPAA) contain provisions governing the use and disclosure of Protected Health Information (PHI) by group health plans, and provide privacy rights to participants in those plans. This section provides an overview of those rights. You will receive from the Plan Administrator a separate "Notice of Privacy Provisions" which contains additional information about how your individually identifiable health information is protected and who you should contact with questions or concerns.

HIPAA applies to medical and prescription drug plans. These plans are commonly referred to as "HIPAA Plans" and are administered to comply with the applicable provisions of HIPAA.

Protected Health Information (PHI) is information created or received by the HIPAA Plans that relates to an individual's physical or mental health or condition (including genetic information as provided under the Genetic Information Nondiscrimination Act), the provision of health care to an individual, or payment for the provision of health care to an individual. Typically, the information identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper, or oral.

The Plan will comply with all privacy requirements defined in the HIPAA Privacy Policy and will use or disclose PHI only if the use or disclosure is permitted or required by HIPAA Regulations and any other applicable Federal, state, or local law.

The HIPAA Plans may disclose PHI to the Plan sponsor only for limited purposes as defined in the HIPAA Privacy Rules. The Plan sponsor agrees to use and disclose PHI only as permitted or required by HIPAA. PHI may be used or disclosed for Plan administration functions that the Plan sponsor performs on behalf of the HIPAA Plans. Such functions include:

- enrollment of eligible individuals;
- eligibility determinations;
- payment for coverage;
- claim payment activities;
- coordination of benefits; and

- claim appeals.

If a Plan participant wants to exercise any of his or her rights concerning PHI, he or she should contact the specific Claims Administrator involved with the PHI in question. The Claims Administrator will advise the Plan participant of the procedures to be followed.

The Plan will require any agents, including subcontractors, to whom it provides PHI to agree to the same restrictions and conditions that apply to the Company or Plan sponsor with respect to such information. The Company or Plan sponsor will report to the Plan any use or disclosure of PHI it knows is other than as permitted by the Plan and HIPAA Regulations.

Any HIPAA Plan will maintain policies and procedures that govern the HIPAA Plan's use and disclosure of PHI. These policies and procedures include provisions to restrict access solely to the previously listed positions/departments and only for the functions listed previously. The HIPAA Plan's policies and procedures will also include a mechanism for resolving issues of noncompliance.

In accordance with the Health Breach Notification Rule (16 CFR Part 18), the Plan sponsor agrees to notify both participants and the Federal Trade Commission of the use or disclosure of any PHI or electronic PHI provided for Plan Administration purposes that is inconsistent with the uses or disclosures provided for, or that represents a PHI Security Incident, of which the Plan sponsor or any Business Associate of the Plan sponsor becomes aware.

ARTICLE VIII

GENERAL PROVISIONS

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

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

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

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

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

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

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

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

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

ARTICLE IX

WRAP PLAN CLAIM REVIEW AND APPEAL PROCEDURE

Time Frames for Processing a Claim

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

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

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

Time Frames for Processing a Claim

Claim Process	Urgent Care Claim	Concurrent Care Claim	Pre-Service Health Claim	Post-Service Health Claim
Claims Administrator determines initial claim is improperly filed (not filed according to Plan procedures) or is not complete	Within 24 hours after receipt of improper or incomplete claim (notification may be oral unless you or your representative request otherwise)	Within 24 hours after receipt of request for extension of urgent concurrent care	Within 5 days after receipt of improper or incomplete claim (notification may be oral unless you or your representative request otherwise)	Not applicable
Claims Administrator determines that you must submit additional information required to complete claim	Within 48 hours after receipt of notice that your claim is incomplete	Not applicable	Within 45 days after receipt of notice that additional information is required	Within 45 days after receipt of notice that additional information is required
Claims Administrator reviews claim and makes determination of:		For urgent care claims, within 24 hours after receipt of the claim, provided request is submitted at least 24 hours prior to expiration of prescribed period of time or number of treatments. If not submitted within 24 hours prior to expiration of		
complete/proper claim	Within 48 hours after the earlier of: receipt of requested information, or at end of period allowed for you to provide information		Within 15 days after the earlier of: receipt of requested information, or at end of 45-day period allowed for you to provide information	Within 30 days after the earlier of: receipt of requested information, or at end of 45-day period allowed for you to provide information

initial claim	Within 24 hours of receipt of initial claim	prescribed period of time or number of treatments, not later than 72 hours after receipt of claim.* For non-urgent care claims, determination will be made within time frame designated for type of claim (pre- or post-service) and prior to expiration of prescribed period of time or number of treatments.*	Within 15 days of date initial claim is received	Within 30 days of date initial claim is received
Extension period,** if required due to special circumstances beyond control of Claims Administrator	Not applicable	Not applicable	Additional 15 days if Plan requires more information from you and provides an extension notice during initial 15-day period	Additional 15 days if Plan requires more information from you and provides an extension notice during initial 30-day period
* A request for extension of treatment will be deemed to be an initial claim. A reduction or termination of approved, ongoing treatment will be deemed to be an adverse claim decision. If the Claims Administrator makes an adverse decision, you will be notified of the reduction/termination within a time frame that allows you to submit an appeal and have a determination on the appeal prior to the expiration of the prescribed period of time or number of treatments. ** Whenever an extension is required, the Plan must notify you before the current determination period expires. The notice must state the circumstances requiring the extension and the date a determination is expected to be made.				

How to Appeal a Claim

To appeal a denied claim or to review administrative documents pertinent to the claim, you or your representative must send a written request to the Plan. The time frames for appealing a claim are shown in the following chart.

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

Time Frames for Appealing Denied Claims				
Appeal Process	**Urgent Care Claim**	**Concurrent Care Claim**	**Pre-Service Health Claim**	**Post-Service Health Claim**
You may submit an appeal of denied initial claim to the Claims Administrator	Within 180 days of receiving notice of denied claim	You will be notified of reduction or termination of benefit in time to submit appeal and receive determination before benefit ends	Within 180 days of receiving notice of denied claim	Within 180 days of receiving notice of denied claim
Claims Administrator	Within 72 hours after	Prior to reduction or	Within 15 days of date	Within 30 days of date

reviews your first appeal and makes determination	appeal is received	termination of benefit	appeal is received	appeal is received
You may submit a second appeal to the Plan Administrator	N/A	N/A	Within 180 days of receiving notice of denied claim	Within 180 days of receiving notice of denied claim
The Plan Administrator reviews your second appeal and makes final determination	N/A	N/A	Within 15 days of date appeal is received	Within 30 days of date appeal is received

Exhaustion Required

If you do not file a claim, follow the claims procedures, or appeal a claim within the timeframes permitted, you will give up all legal rights, including your right to file suit in Federal court, as you will not have exhausted your internal administrative appeal rights. Participants or claimants must exhaust all remedies available to them under the Plan before bringing legal action. Additionally, legal action may not be brought against the Plan more than one year after a final decision on appeal has been reviewed under the Plan.

Adoption of the Plan

The City/County Health Care Plan for Self-funded Wrap and Wellness, effective 07/01/1983, as amended and restated herein, is hereby adopted as of 07/01/2016. This document constitutes the basis for administration of the Plan.

IN WITNESS WHEREOF, the parties have caused this document to be executed on this 6th day of September, 2016.

BY: Becky Perry

TITLE: Chairperson