Plan Document and
Summary Plan Description for the
City of Burlington/County of Des Moines
Self-Funded Dental Benefit Plan

- Dental Benefits

Effective Date: 07/01/2016
Introduction

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

This booklet describes your dental benefits and serves as the Summary Plan Description (SPD) and Plan document for the City of Burlington/County of Des Moines Self-Funded Dental Benefit Plan (“the Plan”).

This document sets forth the provisions of the Plan that provide for payment or reimbursement of Plan benefits. It is written to comply with disclosure requirements under the Employee Retirement Income Security Act (“ERISA”) of 1974, as amended.

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

This Plan and SPD replace all previous booklets you may have in your files. Be sure to keep this booklet in a safe and convenient place for future reference.
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Plan Overview

Your Eligibility

You are eligible for benefits if you are:

- A full-time active employee normally scheduled to work a minimum of 30 hours per week, or a Des Moines County Regional Solid Waste Commission employee normally scheduled to work a minimum of 24 hours per week;
- On the regular payroll of the Company; and
- In a class of employees eligible for coverage.

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

Eligible Dependents

The term dependent shall mean any of the following:

a) The covered employee's spouse by legal marriage or common law marriage, provided such spouse is not legally separated or divorced from the employee; or

b) The covered employee's natural child, adopted child, step children, foster children, court appointed legal guardian, who is:
   1) Under 26 years of age; or
   2) 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.

c) The covered employee's child who is considered to be an "Alternate Recipient" under the terms of a Qualified Medical Child Support Order; or

d) A covered dependent child who reaches the limiting age and is Totally Disabled, 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.

An eligible dependent does not include:

- a person enrolled as an employee under the Plan;
- any person who is in active military services;
- a former Spouse; or
- a person who is covered as a dependent of another employee covered under the Plan. If you and your spouse are both employed by the Company, each of you may elect your own coverage (based on your own eligibility for benefits) or one of you may be enrolled as a dependent on the other's coverage, but only one of you may cover your dependent children.
In addition, an eligible dependent who lives outside the U.S. cannot be covered as your dependent, unless the dependent has established his or her primary residence with you. It is your responsibility to notify the Company if your dependent becomes ineligible for coverage.

**Proof of Dependent Eligibility**

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

**When Coverage Begins**

**For You**

Your dental care coverage begins on the first day of the month following your date of hire and after you meet all eligibility requirements.

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

**For Your Dependents**

If you enroll your eligible dependents within 31 days of your initial eligibility, their coverage begins at the same time as yours.

Coverage for newly eligible dependents will begin on the date they become a dependent as long as you enroll them within 31 days of the date on which they became eligible. If you acquire a new dependent, such as through marriage, coverage will begin on the date they become an eligible dependent (such as of the date of marriage) as long as you enroll the dependent within 31 days of the date on which they became eligible. If you wait longer than 31 days, you may not be able to enroll them until the next annual open enrollment period.

**Your Cost for Coverage**

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

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

New Hire Enrollment
As a newly eligible employee, you will receive enrollment information when you first become eligible for benefits. To enroll in dental coverage, you will need to make your coverage elections by the deadline shown in your enrollment materials. When you enroll in the Plan, you authorize the Company to deduct any required premiums from your pay.
The elections you make will remain in effect until the next June 30, unless you have a qualifying change in status. After your initial enrollment, you will enroll during the designated annual open enrollment period. If you do not enroll for coverage when initially eligible, you will only be eligible for the default coverages designated by the Plan Administrator, as shown in your enrollment materials.
You will automatically receive identification (ID) cards for you and your eligible dependents when your enrollment is processed.

Late Entrant
Your enrollment will be considered timely if your completed enrollment form is received within 31 days after you become eligible for coverage. You will be considered a “late entrant” if:
  - You elect coverage more than 31 days after you first become eligible
  - You again elect coverage after cancelling

Unless the Special Enrollment Rights (see below) apply, if you are a late entrant, you will be required to wait until the next open enrollment period (but no longer than 12 months) to enroll in coverage.

Annual Open Enrollment
Each year during a designated open enrollment period, you will be given an opportunity to make your elections for the upcoming year. Your open enrollment materials will provide the options available to you and your share of the premium cost, as well as any default coverage you will be deemed to have elected if you do not make an election by the specified deadline.
The elections you make will take effect on the following July 1 and stay in effect through June 30, unless you have a qualifying change in status.

Effect of Section 125 Tax Regulations on this Plan
It is intended that this Plan meets the requirements of the Internal Revenue Code Section 125 and the regulations thereunder and that the qualified benefits which you may elect are eligible for exclusion from income. The Plan is designed and administered in accordance with those regulations. This enables you to pay your share of the cost for coverage on a pre-tax basis. Neither the Company nor any fiduciary under the Plan will in any way be liable for any taxes or other liability incurred by you by virtue of your participation in the Plan.
Because of this favorable tax-treatment, there are certain restrictions on when you can make changes to your elections. Generally, your elections stay in effect for the Plan Year and you can make changes only during each annual open enrollment. However, at any time throughout the year, you can make changes to your coverage within 31 days following:
  - The date you have a qualifying change in status as described below;
• The date you meet the Special Enrollment Rights criteria described below.

Qualifying Change in Status

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

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

• your marriage;
• the birth, adoption, or placement for adoption of a child;
• your death or the death of your spouse or other eligible dependent;
• your divorce, annulment, or legal separation;
• a change in a dependent child’s eligibility due to age or eligibility for other coverage;
• a change in employment status for you or your spouse that affects benefits (including termination or commencement of employment, strike or lockout, or commencement of or return from an unpaid leave of absence);
• 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.

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

Special Enrollment Rights

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

You or an affected eligible dependent may also enroll in coverage if eligibility for coverage is lost under Medicaid or the Children’s Health Insurance Program (CHIP), or if you become eligible for premium assistance under Medicaid or CHIP. You must enroll under this Plan within 60 days of the date you lose coverage or become eligible for premium assistance.
This "special enrollment right" exists even if you previously declined coverage under the Plan. You will need to provide documentation of the change. Contact the Plan Administrator to determine what information you will need to provide.

**When Coverage Ends**

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

Coverage for your covered dependents ends when your coverage ends or, if earlier, on the day your dependent is no longer eligible for coverage or becomes eligible for coverage under another employer's plan. However, for a dependent child who reaches limiting age, coverage ends on the last day of the month in which the child reaches the limiting age.

Coverage will also end for you and your covered dependents as of the date the Company terminates this Plan or, if earlier, the date you request termination of coverage for you and your covered dependents.

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

**Cancellation of Coverage**

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

**Rescission of Coverage**

Coverage under the Plan may be rescinded (canceled retroactively) if you or a covered dependent perform an act, practice, or omission that constitutes fraud, or you make an intentional misrepresentation of material fact as prohibited by the terms of the Plan.

Coverage may also be rescinded for failure to pay required premiums or contributions as required by the Plan.

Coverage may be rescinded to your date of divorce if you fail to notify the Plan of your divorce and you continue to cover your ex-spouse under the Plan. Coverage will be canceled prospectively for errors in coverage or if no fraud or intentional misrepresentation was made by you or your covered dependent. You will receive 30 days advance written notice of any cancellation of coverage to be made on a prospective basis.

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

**Coverage While Not at Work**

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

**If You Take a Leave of Absence – FMLA**

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

**If You Take a Military Leave of Absence**

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

The Plan provides dental benefits that cover services you receive from a licensed dentist. The Summary of Dental Benefits chart below shows the covered services under the Plan.

A dental charge is incurred on the date the service or supply is performed or furnished. However, there are times when one overall charge may be made for all or part of a treatment. In this case, the total charge will be apportioned to each separate visit or treatment. The pro-rata charge will be considered incurred as each visit or treatment is completed.

Annual Deductible

A deductible is the amount you must pay for certain covered expenses before the Plan pays benefits. The annual deductible is $25 per person. The annual deductible does not apply to Class A and B Services. The dental deductible is combined with Orthodontia.

Coinsurance

Once you meet your deductible, the Plan pays a portion, or percentage, of certain covered dental expenses, and you are responsible to pay a portion. The percentage you must pay is called your coinsurance. Your coinsurance is determined by the type of service you receive as shown in the chart below.

Maximum Benefit

The maximum annual benefit is $1,500 per person per calendar year for Plans 1 & 2; the maximum annual benefit for Plan 3 is $500 per person per calendar year. There is also a separate individual maximum benefit of $1,500 per lifetime for orthodontia treatment (only available under Plan 1).

Covered Services

In order to be covered, all dental services must be:

- Medically necessary. In order to be deemed medically necessary, a service must conform with generally accepted standards of dental practice. Sometimes there is more than one acceptable form of treatment. The Plan covers the treatment that produces good, professional dental results and costs the least. If you want a more costly treatment, you must pay the difference in cost.

- Provided by a qualified and licensed dentist, physician, denturist, or dental hygienist under supervision of a dentist or physician practicing within the scope of his or her license.

- Reasonable and customary for a covered service or supply. The maximum amount payable by the Plan will be based on the amount determined by the Plan to be the prevailing charge for a covered service or supply. The prevailing charge is based on the complexity of the service and the fee typically charged for a given service by providers with similar training or experience in a given geographical area.

The Plan pays benefits up to the maximum approved amount based on the prevailing charge for a covered service or supply. If your provider charges more than this amount, you are responsible for paying any excess charges above this limit.
A service or supply is not automatically covered simply because it is recommended or prescribed by a dentist. Should you have any questions about whether a service is covered, contact the Claims Administrator shown on your ID card.

**Predetermination of Benefits**

Before starting a dental treatment for which the charge is expected to be $200 or more, you must obtain a predetermination of benefits using a dental claim form. The completed form should be sent to the Claims Administrator who will notify your dentist of the benefits payable under the Plan. If a predetermination of benefits is not submitted, the Plan will make a determination of benefits payable taking into account alternative procedures, services, or courses of treatment, based on accepted standards of dental practice.

**Orthodontic Benefits**

All services must be performed by a licensed dentist. Orthodontia benefits are available only to covered dependents up to age 19. All orthodontia expenses must be reasonable and necessary, and incurred for the diagnosis and treatment of malposed teeth. Benefits are payable only if such treatment is required to move and correct the position of maloccluded or malpositioned teeth, such as an overbite, maxillary and mandibular arches in either a protrusive or retrusive relation of at least one cusp, or a cross bite. Payments for orthodontia treatment will only be made if the participant is still covered under the Plan and is still receiving orthodontic treatment. Benefits will be paid in installments as services are rendered. Claims must be filed by a dentist.

**Two Year Rule**

Enrollment in dental benefits is restricted to a minimum of two years, unless there is a family status change. If enrollment is dropped after a two year cycle, that member shall not be allowed to again select any dental benefits for a period of two years.

**Summary of Dental Benefits**

<table>
<thead>
<tr>
<th></th>
<th>Plan 1</th>
<th>Plan 2</th>
<th>Plan 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Maximum Benefit (per calendar year)</strong></td>
<td>$1,500 per person</td>
<td>$1,500 per person</td>
<td>$500 per person</td>
</tr>
<tr>
<td><strong>Annual Deductible (per calendar year) (does not apply to Class A Services or Class B Services)</strong></td>
<td>$25/person</td>
<td>$25/person</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Orthodontia Maximum Benefit (per lifetime)</strong></td>
<td>$1,500</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Orthodontia Deductible (per calendar year) (combined with Class C deductible)</strong></td>
<td>$25/person</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>TMJ Services ($1,500 lifetime maximum)</strong></td>
<td>50% after deductible</td>
<td>50% after deductible</td>
<td>N/A</td>
</tr>
</tbody>
</table>
* Incentive Mechanism: Allows payment of benefits at 100% of Customary and Reasonable (CR) fees unless the Member did not visit a dentist during the previous calendar year. If the Member did not visit a dentist during the previous calendar year, benefits are payable at 80% of CR.

<table>
<thead>
<tr>
<th>Diagnostic and Preventive Care (Class A) Services</th>
<th>Plan Pays*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan 1, 2 &amp; 3</td>
</tr>
<tr>
<td>Oral exams (limited to 2 per calendar year )</td>
<td>100%</td>
</tr>
<tr>
<td>Bite-wing X-Rays (limited to 2 per calendar year )</td>
<td>100%</td>
</tr>
<tr>
<td>Full mouth x-rays (limited to 1 per every 2 calendar years )</td>
<td>100%</td>
</tr>
<tr>
<td>Prophylaxis (dental or periodontal) - cleaning of the teeth (limited to 2 per calendar year )</td>
<td>100%</td>
</tr>
<tr>
<td>Periapical x-rays (PAS)</td>
<td>100%</td>
</tr>
<tr>
<td>Any x-rays needed to diagnose a condition requiring treatment</td>
<td>100%</td>
</tr>
<tr>
<td>Topical fluoride applications (limited to 2 per calendar year ) (limited to dependent children under age 19)</td>
<td>100%</td>
</tr>
<tr>
<td>Topical application of sealants on permanent molars (limited to 1 per calendar year ) (limited to dependent children under age 17)</td>
<td>100%</td>
</tr>
<tr>
<td>Space maintainers and their fitting</td>
<td>100%</td>
</tr>
<tr>
<td>Emergency palliative treatment to relieve pain</td>
<td>100%</td>
</tr>
</tbody>
</table>

<p>| Therapeutic and Restorative (Class B) Services                                         | Plan Pays* |
|                                                                                       | Plan 1 &amp; 2 | Plan Pays |
|                                                                                       | Plan 3     |
| Extraction of teeth, cutting procedures in the mouth, and treatment of fractures and dislocations of the jaw (but excluding charges for removal of stitches or post-operative exams) | 100%       | 80%       |
| Periodontics (treatment of the gums and support structures of the teeth)             | 100%       | 80%       |
| Root canals and other endodontic treatments                                           | 100%       | 80%       |</p>
<table>
<thead>
<tr>
<th>Therapeutic and Restorative (Class B) Services</th>
<th>Plan Pays*</th>
<th>Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>General anesthetics and their administration in connection with oral surgery,</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Periodontics, fractures, and dislocations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injectable antibiotics</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Fillings or restorations consisting of amalgam, acrylic, silicate, or composite</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>materials</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relining of full or partial dentures if done more than one year after initial</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>installation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occlusal guard, by report — removable dental appliance, which are designed to</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>minimize the effects of bruxism (grinding) covered only by review of dental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>report. (Excludes OTC – non-lab custom appliances)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recementing of inlays, crowns, and bridges</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Consultations with a specialist</td>
<td>100%</td>
<td>80%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Major and Prosthodontic (Class C) Services</th>
<th>Plan Pays*</th>
<th>Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gold restorations, including inlays, onlays, and foil fillings. The cost of</td>
<td>50%</td>
<td>N/A</td>
</tr>
<tr>
<td>gold restorations in excess of the cost for other fillings will be included</td>
<td></td>
<td></td>
</tr>
<tr>
<td>only when the teeth must be restored with gold.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repair of crowns, bridgework, and removable dentures</td>
<td>50%</td>
<td>N/A</td>
</tr>
<tr>
<td>Replacing an existing removable partial or full denture or fixed bridgework,</td>
<td>50%</td>
<td>N/A</td>
</tr>
<tr>
<td>adding teeth to an existing partial denture, or adding teeth to existing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>bridgework to replace newly extracted natural teeth. Applies only if existing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>denture or bridgework was installed at least five years prior to its replacement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and cannot be made serviceable.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rebasing of removable dentures or existing dentures which have not been</td>
<td>50%</td>
<td>N/A</td>
</tr>
<tr>
<td>replaced by a new denture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full to partial dentures, fixed bridges, or adding teeth to an existing</td>
<td>50%</td>
<td>N/A</td>
</tr>
<tr>
<td>denture due to loss of natural teeth while participant</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Major and Prosthodontic (Class C) Services

<table>
<thead>
<tr>
<th>Plan Pays</th>
<th>Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan 1 &amp; 2</td>
<td>N/A</td>
</tr>
</tbody>
</table>

is covered under the Plan, or to replace an existing prosthesis which is over five years old

50% N/A

Crows and gold fillings necessary to restore the structure of teeth broken down by decay/injury (charge for a crown or gold filling is limited to the charge for a silver, porcelain or other filling material unless the tooth cannot be restored with such materials); covered only if the crown or gold filling is over five years old

50% N/A

Implants for crows, bridgework and dentures when member meets criteria (limitation: 1 per tooth every 84 months)

50% N/A

Treatment of disturbances of the Temporomandibular Joint (TMJ) is subject to a $1,500 lifetime maximum, provided the treatment begins before the member’s 19th birthday.

50% N/A

### Orthodontia Benefits

<table>
<thead>
<tr>
<th>Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan 1 only</td>
</tr>
</tbody>
</table>

50%  

Treatment and services necessary to move and correct the position of maloccluded or malpositioned teeth (fully banded only)

### Dental Exclusions

The following list includes some common dental charges which are not covered under the Plan:

- Any services not specifically listed as covered are excluded;
- Charges for dental care that is not medically necessary as prescribed by a physician or dentist;
- Charges for any services not shown in the Summary of Dental Benefits above;
- Charges incurred for completing claim forms or for providing reports;
- Charges for broken or missed appointments;
- Charges in excess of the maximum amount payable under the Plan (see "Maximum Allowed Amount");
- Charges you are not legally obligated to pay;
- Charges for benefits payable under any other coverage of this Plan;
- Charges for services and supplies furnished in a U.S. Government hospital;
- Charges for services provided by a person who normally lives with the Plan participant, you or your spouse, or you or your spouse’s parent, child, brother, or sister;
- Correction of congenital conditions;
- Cosmetic services, including personalization or characterization of dentures, bleaching of teeth, facing on pontics or crowns posterior to the second bicuspids, or precision attachments;
- Crowns for teeth that are restorable by other means for the purpose of periodontal splinting;
- Crowns, fillings, or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, restoring the bite (occlusion) or that are cosmetic in nature;
- Drugs or medicines other than antibiotic injections and desensitizing medications administered by your dentist;
- Duplicate prosthetic devices or other dental applications;
- Education and training in personal oral hygiene, dental plaque control, or dietary and nutritional counseling;
- Expenses for porcelain veneered crowns or pontics in excess of acrylic veneer crowns or pontics;
- Expenses for initial placement of a complete or partial denture or fixed bridgework if it involves replacement of one or more natural teeth missing or lost prior to the effective date of coverage;
- Expenses for any dental services or supplies for treatment of teeth missing prior to the effective date of coverage (including congenitally missing teeth);
- Expenses for facings on pontics or crowns posterior to the second bicuspids;
- Expenses for barrier technique or sterilization of dental equipment and supplies;
- Expenses for care or treatment outside of the United States if travel was for the sole purpose of obtaining dental services;
- Replacement of a lost, missing, or stolen prosthetic device or other dental appliance;
- Retreatment or additional treatment necessary to correct or relieve results of a previous treatment if performed after 90 days of initial procedure;
- Services of anesthesiologists;
- Services or supplies which are covered by any employer’s liability laws;
- Services or supplies which are covered by any workers’ compensation or occupational disease laws;
- Services that do not meet the standards of dental practices, accepted by the American Dental Association;
- Treatment which is considered to be experimental by the dental profession;
- Treatment received because of injury, disease, or dental defect resulting from declared or undeclared war or act of war;
• Treatment received before becoming covered under the Plan or after coverage terminates;
• Veneers (bonding of coverings to the teeth).

For More Information

If you have a question about a covered dental service, or for more information about a specific procedure described above, contact the Claims Administrator at the number listed on the back of your dental ID card.

Administrative Information

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

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

Plan Sponsor and Administrator

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

City of Burlington/County of Des Moines
400 Washington Street
Burlington, IA 52601

Affiliate Employers:

City of Burlington, Iowa
County of Des Moines, Iowa
Burlington Municipal Waterworks
Southeast Iowa Regional Airport Authority
Des Moines County Regional Solid Waste Commission
Two Rivers Levee and Drainage District Association
City of Danville, Iowa

As set forth in Section 3(16) under ERISA, the Plan Administrator will administer this Plan and will be the “Named Fiduciary” for the Plan. The Plan Administrator will have control of the day-to-day administration of this Plan and will serve without additional remuneration if such individual is an employee of the Company. The Plan Administrator will have the following duties and authority with respect to the Plan:

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

In addition, the Plan Administrator has the discretionary authority to determine eligibility under all provisions of the Plan; correct defects, supply omissions, and reconcile inconsistencies in the Plan; ensure that all benefits are paid according to the Plan; interpret Plan provisions for all participants and beneficiaries; and decide issues of credibility necessary to carry out and operate the Plan. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

Plan Year
The Plan Year is July 1 through June 30.

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

Identification Numbers
The Employer Identification Number (EIN) is:

EIN: 47-3024022

Plan Funding and Type of Administration
Funding and administration of the Plan is as follows.

<table>
<thead>
<tr>
<th>Type of Administration</th>
<th>Benefits are self-funded and are administered through contracts with third-party administrators.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding</td>
<td>The Company and employees both contribute to the Plan. The Company will use these contributions to pay benefits to or on behalf of Plan Participants from the Company's general assets. Employee contributions toward the cost of a particular benefit will be used in their</td>
</tr>
</tbody>
</table>
Claims Administrators

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

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

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

Agent for Service of Legal Process
If any disputes arise under the Plan, papers may be served upon:
City of Burlington/County of Des Moines
400 Washington Street
Burlington, IA 52601
Service of legal process also can be made upon the Plan Administrator.

No Obligation to Continue Employment
The Plan does not create an obligation for the Company to continue your employment or interfere with the Company’s right to terminate your employment, with or without cause.

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

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

Payment of Benefits
All benefits are payable when the Plan Administrator receives written proof of loss. Benefits will be payable to the covered participant, unless otherwise assigned.
Payment of Benefits to Others

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

Expenses

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

Fraud

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

Indemnity

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

Compliance with Federal Mandates

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

Non-discrimination

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

Future of the Plan

The Company expects that the Plan will continue indefinitely. However, the Company has the sole right to amend, modify, suspend, or terminate all or part of the Plan at any time.
The Company may also change the level of benefits provided under the Plan at any time. If a change is made, benefits for claims incurred after the date the change takes effect will be paid according to the revised Plan provisions. In other words, once a change is made, there are no rights to benefits based on earlier Plan provisions.
Claims Procedures

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

In-Network Claims — Generally, no claim forms are necessary when you use in-network (participating) providers. Benefits for in-network covered services always are paid to the provider. If you pay the provider for a covered service, you must contact the provider to request a refund.

Out-of-Network Claims — If you use out-of-network (non-participating) providers, you might need to pay them when you receive services, including any coinsurance amount. You must then submit a claim form along with an itemized bill to the appropriate Claims Administrator. In most cases, the Claims Administrator will reimburse you directly. Occasionally, however, the Claims Administrator may reimburse the provider directly for covered expenses. If this happens to you and you already have paid your provider, you must request a refund from your provider.

The steps described below will guide you through the process of submitting your out-of-network claim. To obtain a form, contact your Claims Administrator. Complete a separate claim form for each covered family member who has expenses. If you already paid all or a portion of the fee to the provider, indicate the amount paid on the claim form.

For medical expenses, your Claims Administrator will send you an Explanation of Benefits (EOB) showing what the Plan covered. You may receive a bill from the provider for the remainder of the expense, which will be your responsibility to pay. Send the completed claim form to the appropriate Claims Administrator listed on your ID card along with any proof of payment (i.e., a receipt).

To be eligible for reimbursement under the Plan, a claim must be submitted 365 days after the end of the calendar year in which the expense is incurred. Claims filed after that time may be reduced or denied. If you are unable to file a claim within the prescribed time frame, the Plan Administrator may elect to approve the claim after reviewing any extenuating circumstances if the claim is filed as soon as possible.

Time Frames for Processing a Claim

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

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

The chart below shows the time frames for filing different types of claims with the Plan. If you have any questions about what type of claim you may have or the timing requirements that
apply to your claim, please contact your Claims Administrator at the number shown on your ID cards.
<table>
<thead>
<tr>
<th>Claim Process</th>
<th>Urgent Care Claim</th>
<th>Concurrent Care Claim</th>
<th>Pre-Service Health Claim</th>
<th>Post-Service Health Claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims Administrator determines initial claim is improperly filed (not filed according to Plan procedures) or is not complete</td>
<td>Within 24 hours after receipt of improper or incomplete claim (notification may be oral unless you or your representative request otherwise)</td>
<td>Within 24 hours after receipt of request for extension of urgent concurrent care</td>
<td>Within 5 days after receipt of improper or incomplete claim (notification may be oral unless you or your representative request otherwise)</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Claims Administrator determines that you must submit additional information required to complete claim</td>
<td>Within 48 hours after receipt of notice that your claim is incomplete</td>
<td>Not applicable</td>
<td>Within 45 days after receipt of notice that additional information is required</td>
<td>Within 45 days after receipt of notice that additional information is required</td>
</tr>
<tr>
<td>Claims Administrator reviews claim and makes determination of:</td>
<td>For urgent care claims, within 24 hours after receipt of the claim, provided request is submitted at least 24 hours prior to expiration of prescribed period of time or number of treatments. If not submitted within 24 hours prior to expiration of prescribed period of time or number of treatments, not later than 72 hours after receipt of claim.*</td>
<td>For non-urgent care claims, determination will be made within time frame designated for type of claim (pro- or post-service) and prior to expiration of prescribed period of time or number of treatments.*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>complete/proper claim</td>
<td>Within 48 hours after the earlier of: receipt of requested information, or at end of period allowed for you to provide information</td>
<td>Within 15 days after the earlier of: receipt of requested information, or at end of 45-day period allowed for you to provide information</td>
<td>Within 30 days after the earlier of: receipt of requested information, or at end of 45-day period allowed for you to provide information</td>
<td></td>
</tr>
<tr>
<td>initial claim</td>
<td>Within 24 hours of receipt of initial claim</td>
<td>Within 15 days of date initial claim is received</td>
<td>Within 30 days of date initial claim is received</td>
<td></td>
</tr>
<tr>
<td>Extension period,** if required due to special circumstances beyond control of Claims Administrator</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Additional 15 days if Plan requires more information from you and provides an extension notice during Initial 15-day period</td>
<td>Additional 15 days if Plan requires more information from you and provides an extension notice during initial 30-day period</td>
</tr>
</tbody>
</table>

* 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.

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

You will be notified of the Plan Administrator’s decision in writing. If your claim is denied, the Plan Administrator will give you in writing the specific reason(s) that your claim was denied, the specific reference to the Plan provisions on which the denial was based, any internal rules, guidelines, protocols, or similar criteria used as basis for the decision, a statement that you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim, and a statement regarding your right to bring civil action in Federal court under Section 502(a) of ERISA.

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

Exhaustion Required

If you do not file a claim, follow the claims procedures, or appeal a claim within the timeframes permitted, you will give up all legal rights, including your right to file suit 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.
Coordination of Benefits

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

Non-Duplication of Benefits / Coordination of Benefits

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

Your medical benefits are coordinated with benefits from:

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

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

How Non-Duplication Works

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

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

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

Determining Primary and Secondary Plans

Primary and secondary plans are determined as follows.

- A plan that does not contain a coordination of benefits provision is primary.
- If you are the employee, this Plan normally is primary when you have a covered expense.
- If your covered spouse is the patient, your spouse’s company plan (if applicable) is primary. Your spouse should submit expenses to that plan first, wait for the payment, and then submit the claim under this Plan with copies of the expenses and the primary plan’s Explanation of Benefits (EOB).
- When both parents’ plans cover an eligible dependent child, the plan of the parent whose birthday (month and day) comes first in the calendar year is primary. For example, if your spouse’s birthday is March 15 and your birthday is September 28, your spouse’s plan is primary. If both parents were born on the same day, the plan of the parent who has had coverage in effect the longest will be primary. However, if the other plan does not have this birthday rule and, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits.
- When parents who are legally separated or divorced both cover an eligible dependent child, the following rules apply.
o If the parents have joint custody and there is no court decree stating which parent is responsible for health care expenses, the birthday rule previously stated will apply.

o If one parent has custody, his or her plan is primary and the other parent's plan is secondary. If the parent with custody remarries, the stepparent's plan becomes secondary and will pay before the plan of the parent without custody (the third plan).

o If the remarried parent with custody has no health care coverage, the stepparent's plan is primary and the plan of the parent without custody is secondary.

o Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses and that parent has enrolled the child in his or her plan, that parent's plan is primary.

o When none of the previous rules applies, the plan that has covered the patient for the longer period is primary.

**Coordination with Medicare**

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

The Plan also coordinates with Medicare as follows.

- Mandated coverage under another group plan—If a person is covered under another group plan and Federal law requires the other group plan to pay primary to Medicare, this Plan will be tertiary (third payer) to both the other plan and Medicare.

**Coordination with Auto Insurance Plans**

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

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

- any deductible under the automobile coverage;
- any co-payment under the automobile coverage;
- any expense properly denied by the automobile coverage that is a covered expense; and
- any expense that the Plan is required to pay by law.
For Maximum Benefit

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

Subrogation and Reimbursement

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

Right of Recovery

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

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

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

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

Right to Subrogation

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

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

Right to Reimbursement

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

Third Parties

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

When This Provision Applies To You

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

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

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

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

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

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

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants will be entitled to the following.

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series), if applicable, and updated summary plan description. The administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free-of-charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request the certificate before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.
Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the previously mentioned rights. For instance, if you request a copy of Plan documents (i.e., Summary Plan Descriptions and Summary of Material Modifications) or the latest annual report from the Plan and do not receive it within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If, after you exhaust your appeals, you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. Such suit must be filed within 180 days from the date of an adverse appeal determination notice. In addition, if you disagree with the Plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous), the court may order you to pay these costs and fees.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration at 1-866-444-3272.
Your HIPAA/COBRA Rights

Health Insurance Portability and Accountability Act (HIPAA)

Title II of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations at 45 CFR Parts 160 through 164 (HIPAA) contain provisions governing the use and disclosure of Protected Health Information (PHI) by group health plans, and provide privacy rights to participants in those plans. This section provides an overview of those rights. You will receive from the Plan Administrator(s) and/or Insurer(s) a separate "Notice of Privacy Practices" 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.

**Continuing Health Care Coverage through COBRA**

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

The length of COBRA continuation coverage (COBRA coverage) depends on the reason that coverage ends, called the “qualifying event.” These events and the applicable COBRA continuation period are described below.

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

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

**COBRA Qualifying Events and Length of Coverage**

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

18-Month Continuation

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

- employment ends for any reason other than gross misconduct; or
- hours of employment are reduced.
18-Month Continuation Plus 11-Month Extension

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

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

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

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

36-Month Continuation

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

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

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

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

COBRA Notifications

If you or your covered dependents lose coverage under the Plan because your employment status changes, you become entitled to Medicare, or you die, the Plan Administrator (or its designated COBRA administrator) will automatically provide you or your dependents with additional information about COBRA continuation coverage, including what actions you must take by specific deadlines.
If your covered dependent loses coverage as a result of your divorce, legal separation or a dependent child's loss of eligibility under the Plan, you or your dependent must notify the Company within 60 days of the qualifying event. The Plan Administrator (or its designated COBRA administrator) will automatically send you or your dependent, as applicable, COBRA enrollment information. If you or your dependent fails to provide notification of the event within 60 days, you or your dependent forfeits all continuation of coverage rights under COBRA. To continue COBRA coverage, you and/or your eligible dependents must elect and pay the required cost for COBRA coverage.

**Cost of COBRA Coverage**

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

**COBRA Continuation Coverage Payments**

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

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

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

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

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

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

**How Benefit Extensions Impact COBRA**

If you have a qualifying event that could cause you to lose your coverage, the length of any benefit extension period is generally considered part of your COBRA continuation coverage.
period and runs concurrently with your COBRA coverage. (Also see “Coverage While You Are Not at Work” in the Plan Overview for additional information.)

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

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

**When COBRA Coverage Ends**

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

- The premium for COBRA coverage is not paid on a timely basis (monthly payments must be postmarked within the 30-day grace period, your initial payment must be postmarked within 45 days of your initial election).
- The maximum period of COBRA coverage, as it applies to the qualifying event, expires.
- The individual becomes covered under any other group medical plan, even though the subsequent plan has a pre-existing condition exclusion, so long as the individual has enough creditable coverage to satisfy the subsequent plan’s pre-existing condition exclusion. If the individual does not have enough creditable coverage to meet the new plan’s requirement, he or she may continue to purchase COBRA coverage until the earlier of the day he or she is eligible for the new coverage, or 36 months.
- The individual becomes entitled to Medicare.
- The Company terminates its group health plan coverage for all employees.
- Social Security determines that an individual is no longer disabled during the 11-month extension period.
Definitions

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

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

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

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

ERISA
The Employee Retirement Income Security Act of 1974, as amended, a Federal law that governs group benefit plans.

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

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

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

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

GINA
HIPAA

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

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

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

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

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

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

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

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

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

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

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

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

**WHCRA**

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

The City of Burlington/County of Des Moines Self-Funded Dental Benefit Plan, effective 07/01/1993, 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 16th day of June, 2016.

BY: [Signature]

TITLE: [Signature]