CITY OF WEST DES MOINES
GROUP HEALTH PLAN
VIVID CLEAR RX SUMMARY PLAN DESCRIPTION (SPD)

Plan No. 501
July 2025

This Summary Plan Description (SPD) outlines the basic features of the Vivid Clear Rx Plan, an option under the City of West Des Moines Group Health Plan (Plan), and how it operates to help you receive the maximum advantage from your pharmacy benefit.

This SPD is only a summary of the prescription drug benefits available under the Plan. It may omit details which may be of importance to you in a given situation. If there is any conflict between the SPD and the formal plan documents, the terms and conditions of the plan documents will control.

The plan administrator, City of West Des Moines, has full power, both directly and through its authorized delegates, to administer the coverage described herein, including the power to make discretionary interpretations regarding the terms and provisions of the Plan and to make factual findings with respect to any issue arising under the Plan.

About Vivid Clear Rx and Contact Information

The Prescription Drug Program for City of West Des Moines is administered by Vivid Clear Rx and its affiliates. This Summary Plan Description is only a summary of the key parts of your prescription management portion of your plan. You may contact Vivid Clear Rx toll free at (877) 848-4379, visit www.vividclearrx.com or utilize the mobile app for more details about applicable copays and drug coverages under your Plan benefits.

Plan Description

Plan Name:	City of West Des Moines Group Health Plan
Plan Sponsor:	City of West Des Moines
Employer ID Number:	42-6005359
Plan Number:	501
Plan Year:	July 1 – June 30
Participants of Plan:	See Coverage Eligibility and Effective Date later in this summary plan description.
Plan Administrator and Agent For Service of Legal Process:	City of West Des Moines 4200 Mills Civic Parkway West Des Moines, IA 50265 Service of legal process may be made upon the plan administrator and/or trustees.
How Plan Costs Are Funded:	Plan members and participating employer companies.
Type of Plan:	Group Health Plan

Type of Administration: Self-Funded

Benefits Administered by: Vivid Clear Rx
13220 Birch Drive, Suite 200
Omaha, NE 68164
(877) 848-4379

Questions

If you have questions about your group health plan or are unsure whether a particular service or supply is covered, call the Vivid Clear Rx Care Center at 877-848-4379.

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Coverage Eligibility, Effective Date, and Termination

Participation Requirements

Your participation requirements in the Plan are stated below. Plan participants may be either active employees or their covered dependents. Once you have met the participation requirements, you must also meet eligibility requirements. For information on eligibility requirements, see later in this section.

Active Employees

To be eligible for coverage, you must meet the eligibility requirements of City of West Des Moines.

Eligible Members

You are eligible for coverage if you meet the Plan's eligibility requirements. Your spouse may also be eligible for coverage if spouses are covered under this plan. However, a spouse who is eligible for an employer-subsidized health plan through his or her own employer may not be eligible for coverage under this plan.

Spouse

Spouse means your husband or wife as the result of a marriage that would be legally recognized in the jurisdiction entered.

Child

A child is eligible under the plan member's coverage if the child has any of the following relationships to the plan member:

- A biological 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 biological child a court orders to be covered.

A 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.

In addition, a child must be one of the following:

- Under age 26.
- An unmarried child who is deemed disabled. The disability must have existed before the child turned age 26 and while the child was covered by the City of West Des Moines

Benefit Plan. The Plan considers a dependent disabled when he or she meets the following criteria:

- Claimed as a dependent on the employee's, plan member's, subscriber's, policyholder's tax return; and
- Enrolled in and receiving Medicare benefits due to disability; or
- Enrolled in and receiving Social Security benefits due to disability.

Documentation will be required.

Please note: In addition to the preceding requirements, eligibility is affected by coverage enrollment events and coverage termination events.

Types of Coverage

There are different categories of coverage you may hold under this Plan.

- Single Coverage, the plan member is the only one covered.
- Employee and child(ren) Coverage, the plan member and his or her eligible, dependent child(ren) are covered.
- Employee and Spouse Coverage, the plan member and his or her spouse are covered.
- Family Coverage, the plan member, his or her spouse, and each of his or her eligible, dependent children have coverage. Each covered family member must be listed on the plan member's application or added later as a new member.

Requesting Coverage

If you meet the eligibility requirements and choose to enroll in the City of West Des Moines Benefit Plan, you must contact City of West Des Moines.

Prescription drug coverage under the Plan is bundled with major medical coverage under the Plan. You may only enroll for prescription drug coverage under the Plan if you have also enrolled for major medical coverage under the Plan. Similarly, if you enroll for major medical coverage under the Plan, you will also be automatically enrolled for prescription drug coverage under the Plan.

Waiving Coverage

For inquiries on how to waive coverage, please contact City of West Des Moines.

Contributions

If you meet the eligibility requirements, you may participate in the Plan by contributing toward the cost of your coverage. Weekly or monthly contribution amounts depend on whether you are an active or retired plan participant and the number of dependents, if any, you chose to cover under the plan.

When Coverage Begins

For Coverage inquiries regarding beginning of coverage, please contact City of West Des Moines.

Late Enrollees

A late enrollee is a member who declines coverage when initially eligible to enroll and then later wishes to enroll for coverage. However, a member is not a late enrollee if a qualifying enrollment event allows enrollment as a special enrollee, even if the enrollment event coincides with a late enrollment opportunity (see "Special Enrollment Rights" below).

Except when a special enrollment right is available, a late enrollee may enroll for coverage only during the next annual enrollment period.

Special Enrollment Rights

- **Late Enrollees**. If you decline enrollment in group health coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in such group health coverage if you or your dependents lose eligibility for that other coverage (or if another employer stops contributing toward your or your dependents' other coverage). However, you generally must request enrollment within 30 days after your or your dependents' other coverage ends (or after the other employer stops contributing toward the other coverage).

- **New Dependents**. If you acquire 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 generally must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

- **Children's Health Insurance Program**. Medicaid and the Children's Health Insurance Program ("CHIP") offer free or low-cost health coverage to qualifying children and families. If you are eligible for health coverage under the Plan but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage but need assistance in paying their health premiums. If you are eligible for premium assistance under Medicaid or CHIP, the Plan may be required to permit you and your dependents to enroll in the Plan, so long as you request coverage within 60 days of being determined eligible for premium assistance.

- **Requesting Special Enrollment**. To request special enrollment or obtain more information, contact the Plan Administrator at the address or phone number provided in this Summary Plan Description.

Qualified Medical Child Support Order

If you have a dependent child and you or your spouse's employer receives a Medical Child Support Order recognizing the child's right to enroll in this Plan or in your spouse's benefits plan, the employer will promptly notify you or your spouse and the dependent that the order has been received. The employer also will inform you or your spouse and the dependent of its procedures for determining whether the order is a Qualified Medical Child Support Order (QMCSO). Participants and beneficiaries can obtain, without charge, a copy of such procedures from the plan administrator.

A QMCSO specifies information such as:

- Your name and last known mailing address.
- The name and mailing address of the dependent specified in the court order.
- A reasonable description of the type of coverage to be provided to the dependent or the manner in which the type of coverage will be determined.
- The period to which the order applies.

A Qualified Medical Child Support Order cannot require that a benefits plan provide any type or form of benefit or option not otherwise provided under the plan, except as necessary to meet requirements of Iowa Code Chapter 252E (2001) or Social Security Act Section 1908 with respect to group health plans.

The order and the notice given by the employer will provide additional information, including actions that you and the appropriate insurer must take to determine the dependent's eligibility and procedures for enrollment in the benefits plan, which must be done within specified time limits.
If eligible, the dependent will have the same coverage as you or your spouse and will be allowed to enroll immediately. You or your spouse's employer will withhold any applicable share of the cost of the dependent's health care coverage from your compensation and forward this amount to us.

If you are subject to a waiting period that expires more than 90 days after we receive the QMCSO, your employer must notify the Plan when you become eligible for enrollment. Enrollment of the dependent will commence after you have satisfied the waiting period.

The dependent may designate another person, such as a custodial parent or legal guardian, to receive copies of explanations of benefits, checks, and other materials.

Your employer may not revoke enrollment or eliminate coverage for a dependent unless the employer receives satisfactory written evidence that:

- The court or administrative order requiring coverage in a group health plan is no longer in effect;
- The dependent's eligibility for or enrollment in a comparable benefits plan that takes effect on or before the date the dependent's enrollment in this group health plan terminates; or
- The employer eliminates dependent health coverage for all employees.

- The Plan is not required to maintain the dependent's coverage if:
- You or your spouse no longer pay the cost of coverage; or
- You or your spouse have terminated employment with the employer and have not elected to continue coverage.

Family and Medical Leave Act of 1993

The Family and Medical Leave Act of 1993 (FMLA), requires a covered employer to allow an employee with 12 months or more of service who has worked for 1,250 hours over the previous 12 months and who is employed at a worksite where 50 or more employees are employed by the employer within 75 miles of that worksite a total of 12 weeks of leave per fiscal year for the birth of child, placement of a child with the employee for adoption or foster care, care for the spouse, child or parent of the employee if the individual has a serious health condition or because of a serious health condition, the employee is unable to perform any one of the essential functions of the employee's regular position. In addition, FMLA requires an employer to allow eligible employees to take up to 12 weeks of leave per 12-month period for qualifying exigencies arising out of a covered family member's active military duty in support of a contingency operation and to take up to 26 weeks of leave during a single 12-month period to care for a covered family member recovering from a serious illness or injury incurred in the line of duty during active service.

Any employee taking a leave under the FMLA shall be entitled to continue the employee's benefits during the duration of the leave. The employer must continue the benefits at the level and under the conditions of coverage that would have been provided if the employee had remained employed. Please note: The employee is still responsible for paying their share of the cost of coverage if applicable. If the employee for any reason fails to return from the leave, the employer may recover from the employee that portion of the cost of coverage that the employer paid, provided the employee fails to return to work for any reason other than the reoccurrence of the serious health condition or circumstances beyond the control of the employee.

Leave taken under the FMLA does not constitute a qualifying event so as to trigger COBRA rights. However, a qualifying event triggering COBRA coverage may occur when it becomes known that the employee is not returning to work. Therefore, if an employee does not return at the end of the approved period of Family and Medical Leave and terminates employment with employer or remains on an approved non-FMLA leave of absence, the COBRA qualifying event occurs at that time.

If you have any questions regarding your eligibility or obligations under the FMLA, contact your employer.

Coverage Changes and Termination

Certain events may require or allow you to add or remove persons who are covered by this group health plan.

Coverage Change Events

Coverage Enrollment Events: The following events allow you or your eligible child to enroll for coverage. The following events may also allow your spouse to enroll for coverage if spouses are eligible for coverage under this plan. If your employer offers more than one benefit option, the event also allows you to move from one option to another.

- Birth, adoption, or placement for adoption by an approved agency.
- Marriage.
- Exhaustion of COBRA coverage under another group health plan.
- You or your eligible spouse or your dependent loses eligibility for creditable coverage or his or her employer ceases to make contributions to creditable coverage.
- Spouse (if eligible for coverage) loses coverage through his or her employer.
- You lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) (the hawk-i plan in Iowa).
- You become eligible for premium assistance under Medicaid or CHIP.

The following events allow you to add only the new dependent resulting from the event:

- Addition of a biological child by court order.
- Appointment as a child's legal guardian.
- Dependent child under age 26 loses employer sponsored coverage.
- Placement of a foster child in your home by an approved agency.

Coverage Removal Events: The following events require you to remove the affected family member from your coverage:

- Death.
- Divorce or annulment (if spouses are eligible for coverage under this plan).
- Legal separation, also, may result in removal from coverage. If you become legally separated, notify your employer.
- Child who is not deemed disabled reaches age 26.
- Marriage of a disabled child age 26 or older.

The following events may allow you to remove the affected family members or yourself from your coverage:

- Active military service. See The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), page 78.
- Medicare eligibility. If you become eligible for Medicare, you must notify your employer immediately. If you are eligible for this group health plan other than as a current employee or a current employee's spouse, your Medicare eligibility may terminate this coverage.
- No longer residing, living, or working in the service area.
- Spouse becomes eligible for coverage through his or her employer. Your spouse may be removed from coverage under this plan on the date the spouse's coverage through his or her employer becomes effective.
- Birth or adoption.
- Marriage.

Please note: Removal of yourself will result in the removal of all covered dependents as well.

Requirement to Notify Plan Sponsor

For Requirement to Notify Plan Sponsor inquiries, please contact City of West Des Moines.

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

Your group health plan will fully comply with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If any part of the plan conflicts with USERRA, the conflicting provision will not apply. All other benefits and exclusions of the group health plan will remain effective to the extent there is no conflict with USERRA
USERRA provides for, among other employment rights and benefits, continuation of health care coverage to a covered employee and the employee's covered dependents during a period of the employee's active service or training with any of the uniformed services. The Plan provides that a covered employee may elect to continue coverages in effect at the time the employee is called to active service. The maximum period of coverage for an employee and the covered employee's dependents under such an election shall be the lesser of:

- The 24-month period beginning on the date on which the covered employee's absence begins; or
- The period beginning on the date on which the covered employee's absence begins and ending on the day after the date on which the covered employee fails to apply for or return to a position of employment as follows:
  - For service of less than 31 days, no later than the beginning of the first full regularly scheduled work period on the first full calendar day following the completion of the period of service and the expiration of eight hours after a period allowing for the safe transportation from the place of service to the covered employee's residence or as soon as reasonably possible after such eight hour period;
  - For service of more than 30 days but less than 181 days, no later than 14 days after the completion of the period of service or as soon as reasonably possible after such period;
  - For service of more than 180 days, no later than 90 days after the completion of the period of service; or
  - For a covered employee who is hospitalized or convalescing from an illness or injury incurred in or aggravated during the performance of service in the uniformed services, at the end of the period that is necessary for the covered employee to recover from the illness or injury. The period of recovery may not exceed two (2) years.

A covered employee who elects to continue health plan coverage under the plan during a period of active service in the uniformed services may be required to pay no more than 102% of the full premium under the plan associated with the coverage for the employer's other employees. This is true except in the case of a covered employee who performs service in the uniformed services for less than 31 days. When this is the case, the covered employee may not be required to pay more than the employee's share, if any, for the coverage. Continuation coverage cannot be discontinued merely because activated military personnel receive health

coverage as active duty members of the uniformed services and their family members are eligible to receive coverage under the TRICARE program (formerly CHAMPUS).

When a covered employee's coverage under a health plan was terminated by reason of service in the uniformed services, the waiting period may not be imposed in connection with the reinstatement of the coverage upon reemployment under USERRA. This applies to a covered employee who is reemployed and any dependent whose coverage is reinstated.

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

If you are a covered employee called to a period of active service in the uniformed service, you should check with the plan administrator for a more complete explanation of your rights and obligations under USERRA.

Coverage Termination

The following events terminate your coverage eligibility.

- You cease to be employed by a participating employer when your eligibility is based on employment.
- You become ineligible under the Plan's eligibility requirements for reasons other than loss of employment (e.g., a reduction in your hours of service or transfer to a non-benefit eligible position).
- Your employer or the plan sponsor discontinues or replaces this group health plan.
- See also Nonpayment and Fraud and Intentional Misrepresentation of Material Facts below.

When you cease to be employed by a participating employer and your eligibility is based on employment, your coverage will end on the last day of employment. When your coverage terminates for all other reasons, check with your employer to verify the coverage termination date.

Fraud or Intentional Misrepresentation of Material Facts

Your coverage will terminate immediately if:

- You use this Plan fraudulently; including obtaining unnecessary medical treatment.
- You misrepresent a material fact to the Plan.

If your coverage is terminated for fraud or intentional misrepresentation of a material fact, then:

- We may declare this coverage void retroactively from the effective date of coverage following a 30-day written notice. In this case, we will recover any claim payments made.
- We will retain legal rights, including the right to bring a civil action.

Nonpayment

If you fail to make required payments when due or within the allowed grace period, your coverage will terminate as of the last day of the last period for which the required contributions were paid.

Coverage Continuation

When your coverage ends, you may be eligible to continue coverage under this Plan.

COBRA Continuation

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

The description of COBRA coverage contained here applies only to the group health plan benefits offered under the plan and not to any other benefits offered by your employer (such as life insurance, disability, or accidental death or dismemberment benefits). The plan provides no greater COBRA rights than what COBRA requires. Nothing in the plan is intended to expand the participant's rights beyond COBRA’s requirements.

Prescription drug coverage under the Plan is bundled with major medical coverage under the Plan, so the right to elect COBRA coverage for such benefits is similarly bundled. An election to obtain COBRA coverage for prescription drug benefits may not be made independently. Rather, COBRA coverage for prescription drug benefits is only available if an election is made to obtain COBRA coverage for major medical benefits, and an election to obtain COBRA coverage for major medical benefits will automatically include coverage for prescription drug benefits.

Coverage Entitlement

You, your spouse, and/or your dependent child(ren) will be entitled to elect COBRA if you lose your group health coverage under the plan because of a life event known as a qualifying event. You may be entitled to continue this coverage under COBRA for a period of 18, 29, or 36 months depending on the qualifying event that causes loss of coverage under this plan. See Length of Coverage later in this section.

The following are recognized qualifying events that will entitle you, your spouse, and/or your dependent child(ren) for COBRA Coverage.

You will be entitled to elect COBRA:

- If you lose your group health coverage under the plan because your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

Your spouse will be entitled to elect COBRA if he/she loses his/her group health coverage under the plan because any of the following qualifying events happens:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- You become entitled to Medicare benefits (Part A, Part B or both) prior to your qualifying event; or
- Your spouse becomes divorced or legally separated from you.

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

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- You become entitled to Medicare benefits (Part A, Part B or both);
- You and your spouse become divorced or legally separated; or
- The dependent stops being eligible for coverage under the plan as a dependent child.

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

Your child who is receiving benefits under this plan pursuant to a qualified medical child support order (QMCSO) received by your employer during your period of employment with your employer is entitled to the same rights to elect COBRA as your eligible dependent child.

If you take a Family and Medical Leave Act (FMLA) leave and do not return to work at the end of the leave or terminate coverage during the leave, you (and your spouse and dependent children, if any) will be entitled to elect COBRA if:

- They were covered under the plan on the day before the FMLA leave began or became covered during the FMLA leave; and
- They will lose coverage under the plan because of your failure to return to work at the end of the leave. This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the plan during the leave.

COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period, subject to extension or early termination,

generally applicable to the COBRA qualifying events of termination of employment and reduction of hours. For information on how long you may have COBRA coverage, see later in this section, under Length of Coverage.

Qualifying Events

After a qualifying event occurs and any required notice of that event is properly provided, COBRA coverage must be offered to each person losing coverage under the plan who is a qualified beneficiary. You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the plan is lost because of the qualifying event.

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

When the qualifying event is the end of your employment, your reduction of hours of employment, or your death, COBRA coverage will be offered to qualified beneficiaries. You need not provide notice of any of these three qualifying events.

For the other qualifying events, a COBRA election will be available only if you provide notice in writing within 60 days after the later of:

- The date of the qualifying event; and
- The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the plan as a result of the qualifying event.

The written notice must include the plan name, your name, your Social Security Number, your dependent's name and a description of the event.

IMPORTANT: All notices, elections, and payments related to COBRA and COBRA coverage under the Plan must be provided to the following:

City of West Des Moines
4200 Mills Civic Parkway
West Des Moines, IA 50265

Please note: If these procedures are not followed or if the written notice is not provided during the 60-day notice period, you or your dependents will lose your right to elect COBRA.

Electing Coverage

To elect COBRA, you must complete the Election form that is part of the COBRA election notice and submit it to City of West Des Moines. An election notice will be provided to qualified beneficiaries at the time of a qualifying event. Under federal law, you must have 60 days after

the date the qualified beneficiary coverage under the plan terminates, or, if later, 60 days after the date of the COBRA election notice provided to you at the time of the qualifying event to decide whether you want to elect COBRA under the plan.

Mail the completed Election form to:

City of West Des Moines
4200 Mills Civic Parkway
West Des Moines, IA 50265

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

The election must be postmarked 60 days from the termination date or 60 days from the date the COBRA election notice provided at the time of the qualifying event. Please note: If you do not submit a completed Election form within this period, you will lose your right to elect COBRA.

If you reject COBRA before the due date, you may change your mind as long as you furnish a completed Election form before the due date. The plan will only provide continuation coverage beginning on the date the waiver of coverage is revoked.

You do not have to send any payment with your Election form when you elect COBRA. Important additional information about payment for COBRA coverage is included below.

Each qualified beneficiary will have an independent right to elect COBRA. For example, your spouse may elect COBRA even if you do not. COBRA may be elected for only one, several, or for all dependent children who are qualified beneficiaries. You and your spouse (if your spouse is a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their children. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the COBRA election notice will lose his or her right to elect COBRA coverage.

When you complete the Election form, you must notify City of West Des Moines if any qualified beneficiary has become entitled to Medicare (Part A, Part B, or both) and, if so, the date of Medicare entitlement. If you become entitled to Medicare (or first learn that you are entitled to Medicare) after submitting the Election form, immediately notify City of West Des Moines of the date of the Medicare entitlement at the address specified above for delivery of the Election form.

Qualified beneficiaries may be enrolled in one or more group health components at the time of a qualifying event. If a qualified beneficiary is entitled to a COBRA election as the result of a qualifying event, he or she may elect COBRA under any or all of the group health components under which he or she was covered on the day before the qualifying event. For example, if a

qualified beneficiary was covered under the medical and vision components on the day before a qualifying event, he or she may elect COBRA under the vision component only, the medical component only, or under both medical and vision (only if both components are available as a separate election option to the active employee). Group health plan coverage and prescription drug coverage are bundled, and COBRA may only be elected for both benefits together.

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage. For information on when coverage will terminate, see later in this section, under Termination of Coverage.

When considering whether to elect COBRA, you should take into account that a failure to elect COBRA will affect your future rights under federal law. You should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as coverage sponsored by the spouse's employer) within 30 days after your group health coverage under the plan ends because of one of the qualifying events listed above. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available.

Length of Coverage

When coverage is lost due to your death, your divorce or legal separation, or your dependent child losing eligibility as a dependent child, COBRA coverage can last for up to a maximum of 36 months.

When coverage is lost due to the end of your employment or reduction in hours of employment, and you became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than you as the employee) who lose coverage as a result of the qualifying event can last a maximum of 36 months after the date of Medicare entitlement. For example, if you become entitled to Medicare eight months before the date on which your employment terminates, COBRA coverage under the plan for your spouse and children who lost coverage as a result of your termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). This COBRA coverage period is available only if you become entitled to Medicare within 18 months before the termination or reduction of hours.

Otherwise, when coverage is lost due to the end of your employment or reduction of hours of employment, COBRA coverage generally can last for only up to a maximum of 18 months.

Extending Coverage

If the qualifying event that resulted in your COBRA election was your termination of employment or reduction of hours, an extension of the maximum period of coverage may be

available if a qualified beneficiary is disabled or a second qualifying event occurs. You must provide timely notice of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide timely notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA coverage. Along with the notice of a disability, the qualified beneficiary must also supply a copy of the Social Security Administration disability determination.

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

The disability extension is available only if you provide notice in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

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

The written notice must include the plan name or group name, your name, your Social Security Number, your dependent's name and a description of the event. Notice must be provided to the person and address listed previously.

In all cases, you must also provide this notice within 18 months after your termination of employment or reduction of hours in order to be entitled to a disability extension. For example, if you receive the Social Security Administration's disability determination more than 18 months after your termination of employment or reduction of hours, you will not be entitled to a disability extension, even if the Social Security Administration determined that your disability existed during the first 60 days of your COBRA coverage.

If these procedures are not followed or if the written notice is not provided during the 60-day notice period, then there will be no disability extension of COBRA coverage.

An extension of coverage will be available to your spouse and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following your termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include your death, your divorce or legal separation, or a dependent child's ceasing to be eligible for coverage as a dependent under this plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the plan if the first qualifying event had not occurred. (This extension is not available under this plan when you become entitled to Medicare.)

This extension due to a second qualifying event is available only if the participant provides notice in writing of the second qualifying event within 60 days after the later of:

- The date of the second qualifying event; and
- The date on which the qualified beneficiary would lose coverage under the terms of this plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under this plan).

If these procedures are not followed or if the written notice is not provided during the 60-day notice period, there will be no extension of COBRA coverage due to a second qualifying event.

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

For example, if disability ends June 10, coverage will continue through the month of July (7/31).

Termination of Coverage

Coverage under COBRA will end when you meet the maximum period for your qualifying event, as indicated earlier under Length of Coverage.

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

- Any required premium or other contribution toward the cost of coverage is not paid in full on time (taking into account any available grace period);
- A qualified beneficiary becomes covered, after electing COBRA, under another group health plan;
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA;
- The employer ceases to provide any group health plan for its employees; or
- During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled. For more information about the disability extension period, see Extending Coverage, earlier in this section.
- COBRA coverage may also be terminated for any reason this plan would terminate your coverage or coverage of a beneficiary not receiving COBRA coverage, such as fraud.

You must provide notice in writing within 30 days if, after electing COBRA, a qualified beneficiary first becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage.

COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement (meaning the date enrollment in Medicare becomes effective) or as of the beginning date of the other group health coverage. Repayment of all benefits paid after the termination date will be required, regardless of whether or when you provide notice of Medicare entitlement or other group health plan coverage.

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

If the Social Security Administration's determination that the qualified beneficiary is no longer disabled occurs during a disability extension period, COBRA coverage for all qualified beneficiaries will terminate (retroactively if applicable) as of the first day of the month that is more than 30 days after the Social Security Administration's determination that the qualified beneficiary is no longer disabled. Repayment of all benefits paid after the termination date will be required, regardless of whether or when you provide notice that the disabled qualified beneficiary is no longer disabled. For more information about the disability extension period, see Extending Coverage, earlier in this section.

Coverage Cost and Payment

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

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

Your first payment and all monthly payments for COBRA coverage must be made payable to City of West Des Moines and mailed to:

City of West Des Moines
4200 Mills Civic Parkway
West Des Moines, IA 50265

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

If you elect COBRA, you do not have to send any payment with the Election form. However, you must make your first payment for COBRA coverage not later than 45 days after the date of election. This is the date the Election form is postmarked, if mailed, or the date the Election form is received by the individual at the address specified for delivery of the Election form, if hand-delivered. For more information on electing coverage, see Electing Coverage earlier in this section.

The first payment must cover the cost of COBRA coverage from the time coverage under the plan would have otherwise terminated up through the end of the month before the month in which you make your first payment.

For example, Sue's employment terminated on September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of her COBRA election.

You are responsible for making sure that the amount of your first payment is correct. You may contact the plan administrator at the address provided above to confirm the correct amount of the first payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA and make the first payment for it.

If you do not make the first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under this plan.

After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided at the time of the qualifying event. Under the plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under this plan will continue for that month without any break.

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

If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the plan.

Assistance with Questions

Questions concerning the plan or your COBRA rights should be addressed to the contact or contacts identified below. For more information about rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are also available through EBSA's website.

Notification of Changes. In order to protect your family's rights, you should keep City of West Des Moines informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you receive or provide.

Plan Contact Information

For additional information about you and your dependents' rights and obligations under the plan and under federal law, you should contact the plan administrator. You may obtain information about COBRA coverage on request from:

City of West Des Moines
4200 Mills Civic Parkway
West Des Moines, IA 50265

The contact information for the plan may change from time to time. The most recent information will be included in the most recent plan documents (if you are not sure whether this is the most recent plan document, you may request the most recent one from the plan administrator).

Surviving Dependent Coverage

Your eligible dependents may be eligible to continue their medical, dental, and prescription drug coverage under the City of West Des Moines Benefit Plan in the event of your death. For further inquiries on surviving dependent Coverage, please contact City of West Des Moines.

How to Fill Prescriptions

What You Will Pay

Plan Description

Plan	Standard PPO	Wellness PPO	Savers HDHP
Prescription Drug Tier			
ACA	$0 copay	$0 copay	$0 copay
Copay after DEDUCTIBLE is satisfied, if applicable			
Tier 1 Generic	$10 copay	$10 copay	0% coinsurance
Tier 2 Preferred Brand	$20 copay	$25 copay	0% coinsurance
Tier 3 Non-Preferred Brand	$30 copay	$40 copay	0% coinsurance
Specialty Drug Tier (Maximum 30-day supply)			
Tier 1 – Generic	$30 copay	$40 copay	0% coinsurance
Tier 2 – Preferred Brand	$30 copay	$40 copay	0% coinsurance
Tier 3 – Non-Preferred Brand	$30 copay	$40 copay	0% coinsurance

Copays above are for a 30-day supply of the medication filled through retail or home delivery pharmacy. For a 60-day supply filled through retail or Hy-Vee Home Delivery, you will pay 2 copays. For a 90-day supply filled through retail or Hy-Vee Home Delivery, you will pay 3 copays.

Out of Pocket Expenses

Based on the plan that you have chosen for you and your dependents healthcare needs, there may be deductibles that must be fulfilled before the pharmacy benefits apply. Each individual is required to satisfy their individual deductible until the family deductible is met.

	Standard PPO	Wellness PPO	Savers HDHP
Individual	N/A	N/A	$3,300
Family	N/A	N/A	$5,000

In addition, out of pocket expenses that you incur will apply to the medical plan's out-of-pocket maximum. All plans have a shared out-of-pocket maximum for medical and pharmacy. The amounts listed below are the maximum annual amount you will pay for both medical and pharmacy expenses combined. Each individual is required to satisfy their individual out-of-pocket max until the family out-of-pocket is met.

	Standard PPO	Wellness PPO	Savers HDHP
Individual	$750	$1,500	$3,300
Family	$750	$3,000	$5,000

However, certain amounts do not apply toward your out-of-pocket maximum.

- Amounts subject to general exclusions and conditions for medical benefits. Please refer to the *Exclusions and Limitations* section below for details.

These amounts continue even after you have met your out-of-pocket maximum.

Waived Payment Obligations

Some payment obligations are waived under the Affordable Care Act (ACA) and medications eligible for this are known as Vivid Clear Rx Zero Copay Medications. For more information, see description below.

Vivid Clear Rx Zero Copay Medications

The Patient Protection and Affordable Care Act (PPACA or ACA), commonly known as healthcare reform, was signed into federal law in 2010. The PPACA established a package of items and services known as essential health benefits, which includes preventive services and medications. As of 2014, certain health plans are required to cover recommended preventive services and medications without charging a copayment, coinsurance or deductible.

Recommendations are made in accordance with guidance from U.S. Preventive Services Task Force (USPSTF), Health Resources and Services Administration (HRSA) and Advisory Committee on Immunization Practices (ACIP). These preventive medications are covered as part of the Affordable Care Act (ACA) and are available at no member cost share with a valid prescription. A list of these medications can be found on our website, www.vividclearrx.com

Retail Pharmacy Benefit

For covered prescription drugs obtained at an in-network pharmacy, your plan will provide coverage up to a 90 Day supply (subject to the type of medication and a valid prescription from your physician). Your prescription will be subject to a cost share listed under the "What You Will Pay" section.

Specialty Pharmacy Benefit

Your plan utilizes in-network Specialty Pharmacies, Amber Pharmacy (www.amberpharmacy.com) and Hy-Vee Pharmacy Solutions (www.hvrxsolutions.com). This coverage is for up to a 30-day supply (standard supply), subject to a cost share listed under the "What You Will Pay" section. If your specialty medication prescribed is not available through either Specialty Pharmacy, this will be communicated to your prescribing physician. Vivid Clear Rx will assist as needed.

Specialty Assistance Program

Due to the exceptionally high cost of specialty medications, the plan offers a Specialty Assistance Program that can be used to help members with their prescription copays. The member may contact the program at the number below to see if they qualify for copay assistance. If members chose not to participate in the program, the specialty drug will remain eligible for coverage under the normal provisions of the Plan as stated in the Summary of Benefits.

In most cases, the Specialty Assistance Program will reach out to the member upon their submission of a specialty drug claim, but it is nonetheless the member's responsibility to

contact if interested in the additional savings. The Specialty Assistance Program can be contacted at:

Specialty Assistance Program
1-877-389-9094
info@ascellahealth.com

A current list of specialty drugs subject to the Specialty Assistance Program is available by contacting Vivid Clear Rx at info@vividclearrx.com or 877-848-4379.

Prescription medications covered as essential health coverage per the Affordable Care Act are excluded from the Specialty Assistance Program.

Note that due to HDHP requirements, this plan will not provide reimbursement for benefits under the Specialty Assistance Program until the year's deduction is met. This condition on benefits does not apply for preventive benefits, which are excluded from HDHP rules regarding deductibles.

BENEFIT PROVISIONS	SPECIALTY DRUGS	Maximum Copay is stated in Plan Description
• The Specialty Assistance Program copay is net of the maximum amount available under any manufacturer-provided patient assistance, alternative sourcing, copay card, or similar program. • If the specialty drug is not available through the Specialty Assistance Program, the specialty drug copay is the amount stated in the Plan Description		

Vivid Clear Rx Website

Vivid Clear Rx provides you with online access to additional Plan information and tools such as those listed below. Visit www.vividclearrx.com.

Pharmacy Location Services: Locate an in-network pharmacy
Coverage and Benefits: Print an Rx ID Card, view the Deductible and Out-of-Pocket Maximum Tracker
Drug Search, Pricing and Information: Search for information related to your prescriptions including cost and clinical information.
Claims History: View year-to-date claims.

Benefit Coverage and Limitations

Formulary

The Formulary is a list of medications that are covered by your Plan; however, specific limitations may apply, i.e. quantity of medication based on days' supply. The Formulary applies only to outpatient medications prescribed to members and does not apply to medications used in an inpatient setting (inpatient setting examples would be hospitalization, emergency room, etc.). If you have specific questions regarding your prescription coverage, please contact Vivid Clear Rx at (877) 848-4379.

To be covered, the medication must be:

- Listed on the Formulary;
- Legally obtained in the United States only with a written prescription;
- Deemed both safe and effective by the U.S. Food and Drug Administration (FDA) and approved for use by the FDA after 1962;
- Prescribed by a practitioner prescribing within the scope of his or her license;
- Medically Necessary for your condition (see description in *Exclusions and Limitations* section below); and
- Dispensed by an in-network pharmacy and is a licensed retail pharmacy employing licensed registered pharmacists.

General Covered Medications

- Medications approved by the U.S. Food and Drug Administration that are available to the public only by a prescription from a licensed physician or other licensed provider.
- Diabetic Supplies not classified as Over-the-Counter (includes needles and syringes)
- Specialty Pharmacy Drugs
- Compounded Medications of which holds an ingredient that is covered by the Plan.
- ACA Medication Drug List covered at 100%

General Excluded Medications

- Over the Counter (OTC) medications or their equivalents
- Medications specifically listed as not covered
- Foreign sourced medications
- Experimental drug products or any drug product used in an experimental manner (for more information, see *Exclusions and Limitations* section below)
- Anti-obesity Medications
- Any Medications used for cosmetic purposes

See the *Exclusions and Limitations* section below for more details on what is excluded.

Discretionary Authority

The Plan Administrator is specifically empowered on a case-by-case basis, in a non-discriminatory fashion and when it finds that doing so is in the best interest of the Participant

and not unduly burdensome to the Plan, to deem a drug payable which would otherwise be excluded under the Plan.

Quantity Limitations

There may be quantity limits on certain medicines. Quantity limits are based on the FDA's recommended dosing guidelines for each medication and are reviewed regularly to ensure clinical appropriateness. Limits are set to ensure safety and efficacy in the treatment of various health conditions. Requests for drug quantities above Plan limits require review and authorization by Vivid Clear Rx.

Brand Name Drugs and Generic Drugs

A generic drug is a prescription drug that is marketed by one or more pharmaceutical companies under its nonproprietary name after its patent has expired. A brand name drug refers to a prescription drug that is marketed by one company under its proprietary name before or after its patent has expired.

Generic medications remain your lowest-cost choice — offering you the least expensive alternative without sacrificing safety and effectiveness. Generic drugs are safe and as effective as their brand-name counterparts, and they cost you less. If you are taking a medication that's not on the preferred list, ask your doctor to consider prescribing a lower-cost generic or preferred brand-name drug. To find out which drugs are preferred, log on to www.vividclearrx.com

Compounded Medications

A medication that is compounded typically contains two or more medications that can be either mixed and or combined by a pharmacist. A compounded prescription is generated by your prescriber and is specifically tailored to your health care treatment. Some further points regarding compounded medications:

- One or more of the ingredients must be available by a valid prescription
- One or more of the ingredients must be covered under the Vivid Clear Rx formulary
- Your plan will cover a specific maximum cost for each compounded prescription

Medication Request (Prior Authorization) Process

Prior Authorization (PA)

A program used to validate diagnosis or other treatment information to assure the prescription is being prescribed appropriately. Often times this requires additional information from the prescriber for approval.

The medication request process applies as follows:

Step 1: Vivid Clear Rx clinical staff reviews preliminary information to determine if the prior authorization process is needed. This initial review is intended to minimize the time it takes to start a new medication or to limit interruptions in your current medication therapy.

- **Coverage Exceptions**: Drugs that are identified in the Formulary as needing prior authorization will require evaluation prior to dispensing at a pharmacy. Each request will be reviewed on an individual basis. If the request does not meet established criteria, the request for coverage of the prescription will not be approved and alternative therapy may be recommended and/or prescribed by your physician.

Step 2: If it is determined that authorization is needed, a Prior Authorization Form will be generated by either your licensed provider or the pharmacy filling your medication. This form is then sent to Vivid Clear Rx for further evaluation.

- Your prescribing provider can fax a completed request form to Vivid Clear Rx at 844-755-1817 or submit the request electronically thru the Vivid Clear Rx website, www.vividclearrx.com. The electronic form is located under the Provider tab.
- Prior Authorization is generally not available for prescription drugs that are specifically excluded by the benefit design
- Non-approved requests may be appealed. The prescriber must provide information to support the appeal.

Exclusions and Limitations

In addition to general exclusions listed above, the following medications are excluded from coverage:

- Those not listed on the Formulary
- Any drug or medication that is not medically necessary
- Drugs in excess of a quantity limitation. See *Quantity Limitations* above
- Antigen therapy
- Drugs that are not FDA-approved
- Investigational or experimental drugs
- Compounded drugs that do not contain an active ingredient in a form that has been approved by the FDA and that require a prescription to obtain
- Compounded drugs that contain bulk powders or that are commercially available as a similar prescription drug

- Drugs determined to be abused or otherwise misused by you
- Drugs that are lost, damaged, stolen, or used inappropriately
- Contraceptive medical devices, such as intrauterine devices and diaphragms; these are covered under your medical benefits
- Convenience packaging. If the cost of the convenience packaged drug exceeds what the drug would cost if purchased in its normal container, the convenience packaged drug is not covered
- Most infused drugs. These may be covered under your medical benefits, but contact Vivid Clear Rx at (877) 848-4379 to determine whether an infusion drug is covered.
- Irrigation solutions and supplies
- Medication Therapy Management (MTM) when billed separately
- Therapeutic devices or medical appliances
- Weight reduction drugs
- Self-help drugs.

For purposes of these exclusions, the following standards and limits apply:

- **Medically Necessary.** A key general condition in order for you to receive benefits is that the drug must be medically necessary. Even a drug listed as otherwise covered may be excluded if it is not medically necessary in the circumstances. Vivid Clear Rx determines whether a drug is medically necessary, and that decision is final and conclusive, subject to the right to appeal an adverse benefit determination under the Plan's claim procedures. Vivid Clear Rx's medically necessary analysis and determinations apply to any drug including, but not limited to, medical, mental health, and chemical dependency treatment, as appropriate. Even though a provider may recommend a service or supply, it may not be medically necessary.

  A medically necessary drug is one that a provider, exercising prudent clinical judgment, provides to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and is
  - Provided in accordance with generally accepted standards of medical practice. Generally accepted standards of medical practice are based on: (i) nationally recognized utilization management standards as utilized by Vivid Clear Rx; or (ii) Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; and (iii) Physician Specialty Society recommendations and the views of physicians practicing in the relevant clinical area.
  - Clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease.
  - Not provided primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the illness, injury or disease.

An alternative drug may meet the criteria of medical necessity for a specific condition. If alternatives are substantially equal in clinical effectiveness and use similar therapeutic agents or regimens, we reserve the right to approve the least costly alternative.

If you receive services that are not medically necessary, you are responsible for the cost.

- **Investigational or experimental.** You are not covered for a biological product or drug that is investigational or experimental. You are also not covered for any biological product or drug related to the use of a service, supply, device, biological product, or drug that is investigational or experimental. A treatment is considered investigational or experimental when it has progressed to limited human application but has not achieved recognition as being proven effective in clinical medicine. Our analysis of whether a service, supply, device, biological product, or drug is considered investigational or experimental is applied to medical, surgical, mental health, and chemical dependency treatment services, as applicable.

  To determine investigational or experimental status, we may refer to the technical criteria established by Vivid Clear Rx, including whether a service, supply, device, biological product, or drug meets these criteria:
  - It has final approval from the appropriate governmental regulatory bodies.
  - The scientific evidence must permit conclusions concerning its effect on health outcomes.
  - It improves the net health outcome.
  - It is as beneficial as any established alternatives.
  - The health improvement is attainable outside the investigational setting.

  While we may rely on these criteria, the final decision remains at the discretion of Vivid Clear Rx, subject to the right to appeal an adverse benefit determination under the Plan's claim procedures. You may access our medical policies, with supporting information and selected medical references for a specific service, supply, device, biological product, or drug through the plan sponsor.

  If you receive services that are investigational or experimental, you are responsible for the cost.

Notification of Decision

In case of an adverse decision, the member or their representative (prescriber) will be notified within 15 days of a standard request (faster if expedited). We may extend this time by up to 15 days if the claim determination is delayed for reasons beyond our control. If we do not send a notice of extension within the 30-day period, you have the right to begin an appeal. We will notify you of the circumstances requiring an extension and the date by which we expect to render a decision.

If an extension is necessary because we require additional information from you, the notice will describe the specific information needed. You have 45 days from receipt of the notice to provide the information. Without complete information, your claim will be denied.

If your claim is denied, you will have 180 days to appeal the decision. Information about your appeal rights, including where and how to submit an appeal, will be provided with the notice of your claim denial. See also "Appeals of Adverse Benefit Determinations" below. If you fail to submit an appeal within this timeframe, you will be unable to take any further action related to the claim.

If you have other insurance coverage, our processing of your claim may utilize coordination of benefits guidelines.

Once we pay your claim, our obligation to pay benefits for the claim is discharged. However, we may adjust a claim due to overpayment or underpayment.

Exception Requests for Non-Formulary Prescription Drugs

Prescription drugs that are not listed on the Formulary are not covered. However, you may make an exception request for coverage of a non-formulary drug by contacting Vivid Clear Rx at 844-755-1817 and submitting the requested information to justify the need for an exception. Your prescribing physician or other provider must provide a clinical justification supporting the need for the non-formulary drug to treat your condition. The provider should include a statement that:

- All covered formulary drugs on any level have been ineffective; or
- All covered formulary drugs on any level will be ineffective; or
- All covered formulary drugs on any level would not be as effective as the non-formulary drug; or
- All covered formulary drugs would have adverse effects.

Vivid Clear Rx will typically respond within 72 hours of receiving an Exception Request. For expedited requests, Vivid Clear Rx will respond within 24 hours.

In the event we deny your exception request, you and your provider will be sent additional information regarding your ability to request an independent review of our decision. If the independent reviewer approves your exception request, we will treat the drug as a covered benefit for the duration of your prescription. You will be responsible for out-of-pocket costs (for example: deductible, copay, or coinsurance, if applicable) as if the non-formulary drug is in the highest level of the Formulary. Amounts you pay will be counted toward any applicable out-of-pocket maximums. If the independent reviewer upholds Vivid Clear Rx's denial of your exception request, the drug will not be covered, and this decision will not be considered a final adverse benefit determination, and will not be eligible for further appeals. You may choose to purchase the drug at your own expense.

The Exception Request for Non-Formulary Prescription Drugs process is only available for FDA-approved prescription drugs that are not on the Formulary. It is not available for items that are specifically excluded under your benefits, such as cosmetic drugs, convenience packaging, non-FDA approved drugs, infused drugs, most over-the-counter medications, nutritional, vitamin and dietary supplements, or antigen therapy. The preceding list of excluded items is illustrative only and is not a complete list of items that are not eligible for the process.

Appeals of Adverse Benefit Determinations - Internal Review Process

Step 3: If an adverse benefit determination is rendered, in whole or in part, or a benefit denial is rendered on the member's claim, the member may file an appeal of that determination. If you believe that this determination is not correct, you have the right to appeal the decision by filing an appeal with Vivid Clear Rx. You may call the telephone number below to file an appeal or if you need help understanding our decision. You may submit a copy of the denial notice and a brief explanation of your concern with any other relevant information to file an appeal to the address below:

Vivid Clear Rx
Attn: Prior Authorizations
13220 Birch Drive, Suite 200
Omaha, NE 68164
877-848-4379
FAX 844-755-1817

You may file an appeal with Vivid Clear Rx regarding the decision of your preservice request(s). You have 180 days to file your appeal in writing. The phone number and address to file an appeal are provided above.

If your need for care is urgent, we will respond as soon as possible, but no later than 72 hours after you file your appeal. This is an expedited appeal. In all other cases, we will give you our response no later than 30 days after you file your appeal. This is a standard appeal. There is no charge to you, the member, to file an appeal.

The following information should be included in the appeal request:

- Member's name.
- Member's contract number.
- Information to identify the claim(s) you are appealing.
- A statement explaining that you are filing an appeal and a written explanation of why you believe this case should be approved. Please submit all medical records, peer review articles, and comments for consideration that may support your appeal.

You may designate an authorized representative to file and handle your appeal. Authorized representatives are individuals legally authorized to handle appeals on your behalf. You can ask a friend, family member, lawyer, or your doctor to act for you during your appeal. If you elect to designate an authorized representative to file your appeal, you must submit the Authorized Representative Form, which is included with this letter.

You may request copies of information relevant to your claim free of charge. This request for information must be made in writing.

Appeals of Adverse Benefit Determinations - External Review Process

Step 4: Should the appeal process detailed above still result in an adverse determination, you as a member have the right to request an outside review.

You have the right to request an external review when the determination involved:

- Medical necessity.
- Appropriateness of services or supplies, including health care setting, level of care, or effectiveness of treatment.
- Investigational or experimental services or supplies.
- Concurrent review.
- A rescission of coverage.

An adverse determination eligible for external review does not include a denial of coverage for a service or treatment specifically excluded under this plan.

The external review will be conducted by independent health care professionals who have no association with us and who have no conflict of interest with respect to the benefit determination.

Have you exhausted the appeal process? Before you can request an external review, you must first exhaust the internal appeal process described earlier in this section. However, if you have not received a decision regarding the adverse benefit determination within 30 days following the date of your request for an appeal, you are considered to have exhausted the internal appeal process.

Requesting an external review

You or your authorized representative may request an external review through Vivid Clear Rx by filing an external review request within four (4) months after the date of receipt of the notice of an adverse benefit determination or final adverse benefit determination to the following address:

Vivid Clear Rx
13220 Birch Drive, Suite 200
Omaha, NE 68164
877-848-4379
FAX 844-755-1817

How the review works

Upon notification that an external review request has been filed, Vivid Clear Rx will make a preliminary review of the request to determine whether the request may proceed to external review. Following that review, Vivid Clear Rx will decide whether your request is eligible for external review, and if it is, Vivid Clear Rx will assign an independent review organization (IRO) to conduct the external review. You will be advised of the name of the IRO and will then have

five (5) business days to provide new information to Vivid Clear requested by the IRO. The IRO will make a decision: (i) for standard requests, within 45 days of the date the IRO receives the request for an external review; or (ii) for expedited requests, no more than 72 hours after the IRO receives the request for external review.

Coordination of Benefits

When you present your Vivid Clear Rx card to a pharmacy as the primary payer, your Vivid Clear Rx prescription drug benefits are primary for prescription drugs purchased at the pharmacy. If, under the following rules, your Vivid Clear Rx prescription drug benefits are secondary and you present your Vivid Clear Rx card to a pharmacy as the secondary payer, your Vivid Clear Rx prescription drug benefits are secondary for prescription drugs purchased at the pharmacy.

The following rules are to be applied in order. The first rule that applies to your situation is used to determine the primary plan.

- The coverage that you have as an employee, plan member, subscriber, or policyholder, pays before coverage that you have as a spouse or dependent. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed, so that the plan covering the person as the employee, plan member, subscriber, or policyholder is the secondary plan and the other plan is the primary plan.
- The coverage that you have as the result of active employment (not laid off or retired) pays before coverage that you have as a laid-off or retired employee. The same would be true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, plan member, subscriber, or policyholder or covering the person as a dependent of an employee, member, or subscriber is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- The coverage with the earliest continuous effective date pays first if none of the rules above apply.
- If the preceding rules do not determine the order of benefits, the benefits payable will be shared equally between the plans. In addition, this plan will not pay more than it would have paid had it been the primary plan.

Dependent Children

To coordinate benefits for a dependent child, the following rules apply (unless there is a court decree stating otherwise):

- If the child is covered by both parents who are married (and not separated) or who are living together, whether or not they have been married, then the coverage of the parent whose birthday occurs first in a calendar year pays first. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
- For a child covered by separated or divorced parents or parents who are not living together, whether or not they have been married:

  - If a court decree states that one of the parents is responsible for the child's health care expenses or coverage and the plan of that parent has actual knowledge of those terms, then that parent's coverage pays first. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's coverage pays first. This item does not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
  - If a court decree states that both parents are responsible for the child's health care expense or health care coverage or if a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or coverage of the dependent child, then the coverage of the parent whose birthday occurs first in a calendar year pays first. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
  - If a court decree does not specify which parent has financial or insurance responsibility, then the coverage of the parent with custody pays first. The payment order for the child is as follows: custodial parent, spouse of custodial parent, other parent, spouse of other parent. A custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the calendar year excluding any temporary visitation.
- For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, as outlined previously in this Dependent Children section.
- For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the plan that covered the dependent for the longer period of time is the primary plan. If the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined, as applicable, as outlined in the first bullet of this Dependent Children section, to the dependent child's parent or parents and the dependent's spouse.
- If the preceding rules do not determine the order of benefits and if the plans cannot agree on the order of benefits within 30 calendar days after the plans have received all information needed to pay the claim, the plans will pay the claim in equal shares and determine their relative liabilities following payment. However, we will not pay more than we would have paid had this plan been primary.

Coordination with Noncomplying Plans

If you have coverage with another plan that is excess or always secondary or that does not comply with the preceding rules of coordination, we may coordinate benefits on the following basis:

- If this is the primary plan, we will pay its benefits first.

- If this is the secondary plan, we will pay benefits first, but the amount of benefits will be determined as if this plan were secondary. Our payment will be limited to the amount we would have paid had this plan been primary.
- If the noncomplying plan does not provide information needed to determine benefits, we will assume that the benefits of the noncomplying plan are identical to this plan and will administer benefits accordingly. If we receive the necessary information within two years of payment of the claim, we will adjust payments accordingly.
- In the event that the noncomplying plan reduces its benefits so you receive less than you would have received if we had paid as the secondary plan and the noncomplying plan was primary, we will advance an amount equal to the difference. In no event will we advance more than we would have paid had this plan been primary, minus any amount previously paid. In consideration of the advance, we will be subrogated to all of your rights against the noncomplying plan.
- If the preceding rules do not determine the order of benefits and if the plans cannot agree on the order of benefits within 30 calendar days after the plans have received all information needed to pay the claim, the plans will pay the claim in equal shares and determine their relative liabilities following payment. However, we will not pay more than we would have paid had this plan been primary.

Effects on the Benefits of this Plan

In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other coverage and apply the calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan will credit to its applicable deductible any amounts it would have credited to its deductible in the absence of other coverage.

If a person is enrolled in two or more closed panel plans and if, for any reason including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, coordination of benefits will not apply between that plan and other closed panel plans.

Right of Recovery

If the amount of payments made by us is more than we should have paid under these coordination of benefits provisions, we may recover the excess from any of the persons to or for whom we paid, or from any other person or organization that may be responsible for the benefits or services provided for the covered person. The amount of payments made includes the reasonable cash value of any benefits provided in the form of services.

Plans That Provide Benefits as Services

A secondary plan that provides benefits in the form of services may recover the reasonable cash value of the service from the primary plan, to the extent benefits for the services are covered by the primary plan and have not already been paid or provided by the primary plan.

Coordination with Medicare

Medicare is by law the secondary coverage to group health plans in a variety of situations.

The following provisions apply only if you have both Medicare and employer group health coverage and meet the specific Medicare Secondary Payer provisions for the applicable Medicare entitlement reason.

Working Aged

If you are a member of a group health plan of an employer with at least 20 employees for each working day for at least 20 calendar weeks in the current or preceding year, then in most situations Medicare is the secondary payer if the beneficiary is:

- Age 65 or older; and
- A current regular employee (an employee who works at least 30 hours per week) or full-time employee (an employee who works at least 40 hours per week) or spouse of a current regular-time or full-time employee covered by an employer group health plan.

Working Disabled

If you are a member of a group health plan of an employer with at least 100 full-time, regular-time, or leased employees on at least 50 percent of regular business days during the preceding calendar year, then in most situations Medicare is the secondary payer if the beneficiary is:

- Under age 65;
- A recipient of Medicare disability benefits; and
- A current regular-time or full-time employee or a spouse or dependent of a current regular-time or full-time employee, covered by an employer group health plan.

End-Stage Renal Disease (ESRD)

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

- The beneficiary is eligible for Medicare coverage as an ESRD patient; and
- The beneficiary is covered by an employer group health plan.

If the beneficiary is already covered by Medicare due to age or disability and the beneficiary becomes eligible for Medicare ESRD coverage, Medicare generally is the secondary payer during the first 30 months of ESRD eligibility. However, if the group health plan is secondary to

Medicare (based on other Medicare secondary-payer requirements) at the time the beneficiary becomes eligible for ESRD, the group health plan remains secondary to Medicare.

This is only a general summary of the laws. For complete information, contact your employer or the Social Security Administration.

Workers' Compensation

If you have received benefits under this group health plan for an injury or condition that is the subject or basis of a workers' compensation claim (whether litigated or not), we are entitled to reimbursement to the extent benefits are paid under this plan in the event that your claim is accepted or adjudged to be covered under workers' compensation.

Furthermore, we are entitled to reimbursement from you to the full extent of benefits paid out of any proceeds you receive from any workers' compensation claim, regardless of whether you have been made whole or fully compensated for your losses, regardless of whether the proceeds represent a compromise or disputed settlement, and regardless of any characterization of the settlement proceeds by the parties to the settlement. We will not be liable for any attorney's fees or other expenses incurred in obtaining any proceeds for any workers' compensation claim.

We utilize industry standard methods to identify claims that may be work-related. This may result in initial payment of some claims that are work-related. We reserve the right to seek reimbursement of any such claim or to waive reimbursement of any claim, at our discretion.

Payment in Error

If for any reason we make payment in error, we may recover the amount we paid.

If we determine we did not make full payment, Vivid Clear Rx will make the correct payment without interest.

Legal

Reservation of Rights

City of West Des Moines, as plan sponsor of the Plan, reserves all rights to amend or terminate the Plan or any coverage provided under the Plan and to make changes at any time in the benefits, costs, and other provisions relative to the Plan, including prescription drug coverage under the Plan and coverage for active employees. Those changes could include the complete termination of benefits for all individuals or certain groups of individuals. No current or former employee, spouse, or dependent will acquire any vested (non-forfeitable) right to have benefits or other provisions of the Plan remain unmodified or in effect. In addition, your employer reserves all rights to make changes at any time in the costs or contributions relative to the Plan and any coverage provided under the plan, including prescription drug coverage, notwithstanding any actual or alleged agreement, document, or other communication to the contrary.

No Right to Employment

No plan maintained by City of West Des Moines or any affiliate is intended to create any contractual right of employment, and nothing contained in the Plan or in this SPD shall be construed as a guarantee of employment for any specific period of time or for any specific type of work.

Compliance with Law

The Plan and all benefits offered under the Plan, including prescription drug benefits, are intended to comply with, and will be interpreted, construed, and administered in a manner that complies with, the requirements of all applicable laws, including (to the extent applicable) ERISA, HIPAA, COBRA, USERRA, the Newborns' and Mothers' Health Protection Act, the Women's Health and Cancer Rights Act, the Family and Medical Leave Act, the Mental Health Parity Act, the Mental Health Parity and Addiction Equity Act, the Health Information Technology for Economic and Clinical Health Act, Michelle's Law, the Genetic Information Nondiscrimination Act, the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act, and the Internal Revenue Code.

Your Rights Under ERISA

Employee Retirement Income Security Act of 1974

As a participant in this group health plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

Receive Information About Your Plan and Benefits

You may examine, without charge, at the plan administrator's office or at other specified locations, such as worksites and union halls, 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.

You may obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The plan administrator may make a reasonable charge for the copies.

You may also obtain a summary of the plan's annual financial report. The plan administrator is required by law to furnish you with a copy of this summary annual report.

Continued Group Health Plan Coverage

You have the right to 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. However, you or your dependents may have to pay for such coverage. For more information on the rules governing your COBRA continuation coverage rights, review this summary plan description and the documents governing the plan.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of your employee benefits plan. The people who operate the 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.

Enforcement of Rights

If your claim for a covered 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 above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in 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 plan administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. 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. In all cases, however, you may not file suit in federal court unless and until you have exhausted any and all administrative remedies and review procedures available to you by law or under the terms of the Plan. 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, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have 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 the telephone directory, or write to:

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 may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Plan Sponsor has ultimate authority and responsibility to ensure that its plan documents are in compliance with ERISA. Plan Sponsor may not rely on any sample language provided by VCRx for its plan documents to assert any claim against VCRx based on or arising out of such reliance. VCRx will not be liable for any claim for damage that results either directly or indirectly from reliance on any sample language provided by VCRx.