CORTLAND BANKS

EMPLOYEE BENEFIT PLAN SUMMARY

HEALTH REIMBURSEMENT BENEFITS

Effective April 1, 2014, medical benefits for Cortland Banks will be insured by United Healthcare (UHC). Cortland Banks will continue to share in the cost of your medical benefits by funding a portion of your claims through a health reimbursement account (HRA) administered by Enterprise Group Planning, Inc. (EGP). Purchasing a high deductible plan lowers the total cost of benefits for you and the bank.

Medical coverage – There will be a $1,000 single employee /$2,000 family deductible, then 80/20 or 50/50 co-insurance. Based on your participation and provider choices, the plan will offer different levels of coverage.

- When utilizing the United Healthcare Tier 1 Provider network, co-pays will continue to be offered for physician office visits. Co-pays will be $30 for Primary Care physician and $60 for Specialist office visits. Providers not designated as Tier 1 will be subject to the deductible and 50% co-insurance.
- The health reimbursement account (HRA) will continue, but will be subject to the guidelines indicated.
- The deductible will be reimbursed at 50%, from the first dollar spent. The maximum deductible reimbursement will be $500 per single employee and $1,000 per Family.
- After you have satisfied your deductible, co-insurance will be covered at 80% for many services, while other services will require 50% co-insurance. The coverage is indicated on your Summary of Benefits and Coverage (SBC); please refer to your policy for specific coverage details.
- When you participate under the required program guidelines and qualify for reimbursement under our HRA, your maximum out of pocket will be limited to $2,000 if you have single coverage and $4,000 if you have family coverage, which includes your deductible.
- For example, this means that after you satisfy your deductible, for any claim for which co-insurance will apply at 80%, UHC will cover 80% of the cost, the HRA will cover 10% and 10% will be covered by you (out-of-pocket expense). For any claims covered at 50%, UHC will cover 50% of the cost, the HRA will cover 25% and 25% will be covered by you.

For all non-emergency care new rules for HRA reimbursement will apply.

Reimbursements through the HRA are for in-network claims only and require utilization of both DBMS Care Coordination and the UHC myHealthcare Cost Estimator (instructions follow).

In order for an HRA claim to be considered for payment, two new steps are required in non-emergency situations—the use of 1) DBMS Care Coordination and 2) the UHC myHealthcare Cost Estimator (HCE).

1) Call DBMS at 800-728-0327 and identify yourself as a member from Cortland Banks. They will be able to assist you and will log the call and notify EGP of the discussion.

DBMS is your care advocate before care begins, as well as once it is in progress. Take advantage of their services, they are an invaluable resource. For information regarding DBMS care coordination, please see the information that is being provided separately.

2) Sign in to myuhc.com and search the myHealthcare Cost Estimator (HCE) for the service you are expecting to receive.

- Log in to your myuhc.com account, choose "**$ Estimate Health Care Costs**" and enter your zip code.
- Select "**get started**", then select the service you are considering by typing it in the space provided.
- Select a "**care pathway**" for the services you will be considering.
- Results can be sorted by cost; **green** providers are the lowest cost providers, followed by **grey** and then **red**. You will need to review your provider options and choose either a **green** or **grey** provider for each service in the care pathway. If no **green** or **grey** providers are available in the care pathway, **red** providers will be reimbursed through the HRA.
- **Note**: If you choose any **red** provider in the care pathway, you will be disqualified from receiving the HRA reimbursement for that course of treatment. Also, if you elect not to participate in previewing the Treatment Cost Estimator and following the guidelines, you will not be eligible for HRA reimbursement.

Once you have selected the green and grey providers, print the final summary and include with the submission of your EOB and provider bill to EGP. Failure to provide the HCE summary will make the HRA claim ineligible.

Below are hyper links to help you understand how to find and use the myHealthcare Cost Estimator:
http://www.welcometomyuhc.com/hcce-review/video/b2c/
http://www.welcometomyuhc.com/hcce-review/video/narrated/

If you need any assistance understanding and building a summary using the HCE, your HCE specialist at *EGP can be reached at 440-349-2210 or 800-229-2210. For Sue LaCavera dial extension 139, for Donna Sulhan dial extension 119 between 9:00 am and 4:30 pm M-F. If you are having trouble logging in to myuhc.com or to review questions about the HCE, you can call the Technical Support team at UHC at 877-844-4999.
UHC Customer Service is an additional resource at 800-357-0978 (On your UHC ID card).
Please note: EGP will provide assistance with the myHealthcare Cost Estimator to help you understand how it works: however, they will not be directing or advising which providers to select. That will be your choice.

Some Additional Tips:

Try to negotiate all claims with your provider, whenever possible. If the provider agrees to a lower reimbursement, your out of pocket cost will be reduced. If your provider is in the UHC network and you can negotiate to have the claim covered at a cost no higher than the highest green level reimbursement on the HCE, EGP can accept the negotiated rate and the HRA will cover the claim, as if it were green or grey. Provide the original HCE summary, the EOB and the billing from the provider for reimbursement. See HRA Reimbursement on the next page.

LabCorp is under a national provider contract with UHC and they offer competitive rates for lab work. Go to www.labcorp.com to find a local location. LabCorp is not listed on the HCE, but will be treated the same as any green provider for HRA reimbursement due to their preferred discounts. Feel free to contact Labcorp prior to service to confirm their cost. You may also search the myHealthcare Cost Estimator for lab services like any other service.

In network Convenience Care Clinics will be treated the same any green primary care providers for HRA reimbursement.

When you sign in to myuhc.com, in addition to using the HCE, you will also be able to review your claims and print your EOB's for HRA claim submission.

Please check with your provider before scheduling your appointment or receiving services to confirm whether they are participating in the network.

UHC provides their Care 24 Nurse line, which is available 24 /7. They will help you to look up providers and you can specifically request Tier 1 providers or request locations of Emergency rooms, Urgent care or Convenience Care clinics near you. This service is convenient while near your home and certainly valuable when traveling. The phone number for Care 24 is 888-887-4114 and is on your ID card.

Cortland Banks will have available upon request, a current PDF referencing Tier 1 Providers within 25 miles of Niles, Ohio 44446.
Additionally, a PDF indicating Urgent Care and Convenience Care clinics will be available for each branch location.

Look up your current or new prescriptions through Optum Rx, available on myuhc.com. Consider mail order options through Optum Rx to save cost.

You will be provided with an ID card with EGP and DBMS contact information and instructions.

HRA Submission:

Your HRA will be funded by your employer, and EGP will pay the HRA reimbursement to the providers directly. All that is needed from you will be the HCE printed in color, indicating the Green or Grey providers, the Explanation of Benefits (EOB) form you receive from UHC, balance due statement from your provider and your name, your dependant's name (if applicable) and company name. **Please fax or mail to EGP at (440)349-4268 or mail to 5910 Harper Road, Solon, OH 44139. Also keep a copy for your records.**

Co-pays for all services are your responsibility and are not eligible for reimbursement under your HRA. See below for co-pays, plan changes will be made effective 4/1/14.

- The Co-pays for prescription drugs are $10/25/45 and follow the UHC formulary.

- The physician co-pay is $30 for Premium Designated Tier 1 primary care physicians and $60 for Premium Designated Tier 1 specialists. Non-Premium Designated providers are subject to the deductible and 50% co-insurance for both outpatient and surgical care. Most routine diagnostic x-ray and lab services will be covered subject to your deductible and 80% co-insurance.

- The Emergency Room co-pay is $300 and then charges associated with that visit will be covered at 80%. If admitted to the hospital, the deductible and co-insurance will apply.

- The Urgent Care co-pay is $100 and then charges associated with the Urgent Care visit will be paid at 100%. Treatment at a Convenience Care Clinic or Lab Services provided by Lab Corp will be covered subject to your deductible and 50% co-insurance, but covered as a green provider without requiring the TCE printout for reimbursement. Convenience care clinics are often the most cost effective care settings and will be reimbursed through your HRA.

The Flexible Spending Account will continue to allow you to put away funds to be used toward your deductible or co-insurance or qualified medical expenses on a pre-tax basis.

Simply Engaged Wellness Program:

In order to receive the lower employee contribution, you will responsible to complete a Health Risk Assessment (HRA) through UHC's Simply Engaged program. You and your spouse will each receive a $75 gift card after completion of the assessment. The information collected in the HRA is protected under HIPPA and will not be shared with your employer. A description of the Simply Engaged program will be provided separately.

The bank will be updated by UHC upon completion of your Health Risk Assessment, thereby allowing them to monitor and continue to charge the lower contribution amount to employees that comply with the new requirement by July 1, 2014.

UHC provides the following information for you to consider:

Choosing the right health setting - Primary Care Physician, Urgent Care, or Emergency Room

Should I use emergency or urgent care?

Primary Care Physician

When you or a loved one is hurt, you want the best care. Your doctor knows you and your health history. He or she can access your medical records. And, he or she can provide you follow-up care or refer you to specialists. If it's not urgent, it's usually best to go to your own doctor's office.

Urgent Care

Sometimes, you may need care fast. But, your Primary Care Physician may be unavailable. You may want to try an urgent care center. They can treat many minor ailments. Chances are, you won't have to wait as long as at the ER. You may pay less, too.

An urgent care center can help with:
Sprains
Strains
Minor broken bones (example: finger)
Minor infections
Small cuts
Sore throats
Rashes

Emergency Rooms

You may be tempted to go to the emergency room (ER). But, this may not be the best choice. At the ER, true emergencies are treated first. Other cases must wait--sometimes for hours. And, it may cost you more.

Go to the ER for:
Heavy bleeding
Large open wounds
Sudden change in vision
Chest pain
Sudden weakness or trouble talking
Major burns
Spinal injuries
Severe head injury
Difficulty breathing
Major broken bones

PLAN INFORMATION

Plan Sponsor & Plan Administrator:

The organization providing employee benefits and responsible for management of the Plan:

Cortland Banks
194 W. Main Street
Cortland, OH 44410

Plan ID Number: 34-0165477
Plan Year End: March 31, 2015

Agent for Legal Process:

Legal Notices may be filed with, and legal process served upon the Plan Administrator

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer. The Plan is not insured.

NOTIFICATION OF CONTINUATION OF HEALTH CARE COVERAGE

This Health Reimbursement Plan follows the Continuation Coverage Provisions of the Insured Plan and all required continuation notices are provided by the Insured Plan, carrier or administrator.

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

Continue health care coverage for a Plan Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Employees or dependents may have to pay for such coverage.

Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under this group health Plan, if an Employee or dependent has Creditable Coverage from another plan. The Employee or dependent should be provided a certificate of Creditable Coverage, free of charge, from the group health plan or health insurance issuer when coverage is lost under the plan, when a person becomes entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if a person requests it before losing coverage, or if a person requests it up to 24 months after losing coverage. Without evidence of Creditable Coverage, a Plan Participant may be subject to a Pre-Existing Conditions exclusion for 12 months (18 months for Late Enrollees) after the Enrollment Date of coverage.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has 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 a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Plan Participant should contact either 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 available through EBSA's website.)