

County of Kent Dental Plan

Effective January 1, 2015

TABLE OF CONTENTS

INTRODUCTION	1
PLAN HIGHLIGHTS	1
Claims Administration.....	1
Amendment and Termination	1
Appeals	2
SCHEDULE OF DENTAL BENEFITS	3
PARTICIPATION	4
ELIGIBILITY	4
Employees.....	4
Dependents	4
ENROLLMENT	6
Normal Enrollment.....	6
Open Enrollment.....	7
Qualified Medical Child Support Orders	8
LEAVES OF ABSENCE	9
FMLA.....	9
Other Leaves of Absence	9
TERMINATION OF COVERAGE	11
Termination of Employee Coverage	11
Termination of Dependent Coverage.....	11
COBRA CONTINUATION OF COVERAGE	12
Qualified Beneficiaries.....	12
Qualifying Event – Employee.....	12
Qualifying Event – Dependents	12
Notification.....	13
Notice and Election.....	13
Duration of Coverage	13
Cobra for TAA Eligible Persons.....	15
DENTAL BENEFITS	16
COVERED CHARGES	16
Type I Services – Diagnostic and Preventive	16
Type II Services – Basic	17
Type III Services – Major.....	17
Type IV Services – Orthodontia.....	18

EXCLUSIONS	18
BENEFIT DETERMINATION	21
COORDINATION OF BENEFITS	21
Order of Benefits	22
Exchange of Information.....	23
Facility of Payment	24
Right of Recovery	24
ADMINISTRATIVE PROVISIONS.....	25
Conditions for Payment of Benefits	25
Payment of Benefits	25
Benefit Terms	25
CLAIMS.....	25
Claim Forms	25
Claim Filing.....	26
Claims Appeal and Review Procedure	30
OTHER IMPORTANT PROVISIONS	32
Plan Document.....	32
Amendment and Termination	32
Participant Contributions	32
Due Date of Participant Contributions	32
Plan Funding	32
Confidential Medical Information	33
Limits of Liability	33
Construction	33
Effective Date	33
PRIVACY OF HEALTH INFORMATION.....	34
Uses and Disclosures.....	34
Separation Between Plan and Plan Sponsor.....	36
Filing Complaints	36
GLOSSARY OF DEFINED TERMS	37
SUMMARY PLAN DESCRIPTION	
AND STATEMENT OF RIGHTS	42

INTRODUCTION

The *employer* has created this *plan* to provide dental benefits to its employees and their eligible *dependents*. This booklet summarizes the provisions of that *plan*.

PLAN HIGHLIGHTS

CLAIMS ADMINISTRATION

Although the *employer* pays all claims out of its own assets and retains discretionary authority over any benefit questions that may arise, it has hired a third party administrator to provide routine claims administration services. These services are provided to the *plan* by:

**Professional Benefits Services
2959 Lucerne Dr. SE, Suite 205
Grand Rapids, MI 49546
616-285-2480 or 1-800-732-3412**

The *claims administrator* is not an insurer of benefits or a fiduciary of the *plan*; it has no discretionary authority with respect to matters of eligibility or benefits; it is not responsible for *plan* financing and does not guarantee *plan* benefits.

All claims should be filed with the *claims administrator* at the address indicated above. See the Claims section of this *plan* for additional information on how to file claims.

AMENDMENT AND TERMINATION

The *employer* has the right to amend the *plan* at any time. The *employer* will notify *participants* of any changes as required by law. However, this booklet may not contain all amendments and some changes may go into effect before notice is received. A complete copy of the Plan Document is available as described in the ERISA Statement of Rights at the end of this booklet.

The *employer* intends that this *plan* will continue indefinitely. However, future circumstances cannot be foreseen and therefore the *employer* has reserved the right to terminate this *plan* at any time. Expenses incurred after this *plan* ends will not be covered.

The Other Important Provisions section of the *plan* contains additional information about amendment and termination.

APPEALS

Any *covered person* who disagrees with a decision made by the *plan* regarding his eligibility or benefits may appeal that decision by following the procedures described in the Claims section of this *plan*. This includes, but is not limited to, decisions regarding:

- eligibility, enrollment and termination of coverage.
- COBRA eligibility, election and termination.
- the amount of benefits payable under the *plan*.
- preauthorization of services and supplies when required by the *plan*.
- coordination of benefits.

Appeals that do not follow the procedures described in the Claims section will not be considered.

SCHEDULE OF DENTAL BENEFITS

Verification of Eligibility: 616-285-2480 or 1-800-732-3412

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

PLAN LIMITS

Maximum Calendar Year Benefit for Combined Type I, II, III and IV Services (Airport Command Officers, Circuit Court Referees, Commissioners, Captains and Lieutenants, Court Reporters, Elected Officials, Judges, MPP, Prosecuting Attorneys, Teamsters-Parks, Teamsters-PHNs, UAW) Only one annual family maximum will apply if both members of the household are eligible to participate in the County Dental Plan.

Family \$2,500

Maximum Calendar Year Benefit for Combined Type I, II, III and IV Services (POAM) Only one annual family maximum will apply if both members of the household are eligible to participate in the County Dental Plan.

Family \$2,400

Maximum Calendar Year Benefit for Combined Type II, III and IV Services (KCDSA). Only one annual family maximum will apply where a married couple are both eligible to participate as employees under the County dental plan.

Family \$1,600

DEDUCTIBLES AND COINSURANCE PERCENTAGES

Class A - Type I (Preventive) Services see attached schedule

Class B - Type II (Basic) Services 50%

Class C - Type III (Major) Services 50%

Class D - Type IV (Orthodontic) Services 50%

PARTICIPATION

ELIGIBILITY

The *plan* provides coverage for persons who are *plan participants* and to their eligible *dependents*.

EMPLOYEES

To become a *participant*, a person must be an eligible employee.

An eligible employee is any individual whom the *employer* regards as a full-time common law employee and who is regularly scheduled to work at least 40 hours per week for the *employer*.

Any person that the *employer* classifies as a part-time, temporary, leased or seasonal employee or independent contractor is not an eligible employee. No reclassification of any person by a government authority shall entitle a person to retroactive coverage under this *plan*.

DEPENDENTS

An eligible *dependent* is a *participant's*:

- legal *spouse*; or
- *child*, until the end of the month in which they reach age 26. The child may remain covered to any age if he is totally and permanently disabled by either a physical or mental condition prior to age 19.

The term *dependent* does not include any person who is on active duty as a member of the armed forces of any country.

ABOUT THIS SECTION

The Participation section of the *plan* describes:

- who is eligible for coverage under the *plan*.
- how to become covered.
- when coverage begins.
- how and when coverage ends.
- continuation coverage under COBRA.

Who Qualifies as a Dependent Child?

A *child* is a *participant's* natural child or legally adopted child (including a child placed with a *participant* for adoption). It also includes a *participant's* stepchild or legal ward who resides in the *participant's* household and who the *participant* legally claims as a *dependent* for federal income tax purposes.

Sponsored Dependents: Persons who are over age 26, may be eligible for coverage as a *sponsored dependent* if they meet the following requirements:

- Related to the participant by blood, marriage, or legal adoption; and
- Is dependent upon the participant for more than half of their support.

Participants are responsible for paying 100% of the cost of coverage for sponsored dependents.

NOTE: No person shall be covered or eligible for coverage under this *plan* as both an employee and a *dependent* or as a *dependent* of more than one employee. No *dependent* of an employee may be covered unless the employee is also a *participant*.

ENROLLMENT

NORMAL ENROLLMENT

To become covered, an eligible employee must enroll himself and his eligible *dependents* by properly completing an enrollment form and returning it to the *employer* during the enrollment period and agreeing to pay any contribution for coverage which may be required. Must sign up within 4 business days of hire

If the employee enrolls during the enrollment period, the employee and his *dependents* will become *covered persons* on:

- his date of hire, if he is hired on the first day of the month; or
- the first day of the month following his date of hire.

ENROLLMENT EXAMPLE

Following is a sample time line for a new employee:

Hire Date:	July 15
Eligible Employee:	July 15
Enrollment Period:	July 15 to July 18
Date employee becomes covered:	August 1

Newly-Acquired Dependents: The following persons are eligible for enrollment as described in this section:

- an eligible employee who is not a *participant* may enroll when a person becomes his *dependent* through marriage, birth, adoption or placement for adoption. The *dependent* may also enroll at that time.
- a *participant* may enroll a person who becomes his *dependent* through marriage, birth, adoption or placement for adoption.
- an eligible employee and his *spouse* may enroll when the employee becomes married or when a child becomes a *dependent* through birth, adoption or placement for adoption.
- a *participant* may enroll a person who becomes his legal *spouse* after he becomes covered under this *plan*. A *participant* may also enroll his *spouse* if a child becomes the *participant's* eligible *dependent* through birth, adoption or placement for adoption.

An eligible employee may enroll himself and his *dependents* by submitting a written application to the *employer* during the 30 day period after the date of the marriage, birth, adoption or placement for adoption. Coverage will become effective:

- in the case of marriage, on the first day of the following month after the marriage; or
- in the case of a birth or adoption on the day of event; or
- in all other cases, on the first day of the following month following date of event.

provided the employee is, or also becomes, a *participant* on that date and pays any contribution that the *employer* may require for coverage.

OPEN ENROLLMENT

After the end of the normal enrollment period, an eligible employee may enroll himself and his *dependents* by properly completing an application for coverage and returning it to the *employer* during an open enrollment period. The employee must agree to pay any contribution for coverage that may be required. Open enrollment is generally during the months of October or November each year.

Coverage in the case of an employee will begin on the first day of the following January provided the employee is otherwise eligible and *actively at work* on that date. Coverage for a *dependent* will begin on the first day of the following January provided the employee is covered and the *dependent* is otherwise eligible on that date.

If any conditions of enrollment are not met on the date coverage would normally become effective, coverage will begin on the first day of the month that all the conditions are met.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

The term Qualified Medical Child Support Order (QMCSO) means:

- any judgment, decree or order issued by a court of competent jurisdiction which satisfies the requirements for a QMCSO as set forth in section 609(a) of ERISA;
or
- a National Medical Support Notice (NMSN) issued by a state agency that administers child support enforcement programs and satisfies the requirements of rules developed pursuant to the Child Support Performance and Incentive Act of 1998.

Upon receipt of an order purporting to be a QMCSO, the *plan administrator* shall promptly notify the employee and each child who is the subject of such an order of its receipt and of the *plan's* procedures for determining whether it is a QMCSO. It will also notify the employee and each child affected by such an order of its

determination. Copies of this notice shall be sent to any person designated by such child as representative for receipt of such notices. In the case of a NMSN, all communications by the *plan administrator* must also be sent to the issuing agency.

Upon determination that an order is a QMCSO, a child who is the subject of such an order shall be treated as a beneficiary under this *plan*, without regard for any provisions in this *plan* limiting eligibility for coverage on the basis of financial support, residency or enrollment date. If any additional contribution from an employee is required to provide coverage for such child, the *employer* will automatically withhold such additional contribution from the employee's wages.

Coverage will begin on the first day of the month following the date the *plan administrator* determines that the order meets the criteria for a QMCSO.

Any benefits paid under this *plan* pursuant to a QMCSO in reimbursement for covered expenses paid by a child who is the subject of such an order or by such child's custodial parent or legal guardian shall be paid to such child or his custodial parent or legal guardian.

LEAVES OF ABSENCE

FMLA

If a covered employee takes an approved leave of absence that qualifies as family or medical leave under the Family and Medical Leave Act of 1993 as amended (FMLA), he may continue dental coverage for himself and his covered *dependents* for the duration of that leave by paying the same amount for coverage as he would have paid if he were an active employee.

If a covered employee does not maintain coverage during FMLA leave, he may reinstate coverage upon his timely return from leave on the same terms as before taking leave. Any preexisting condition limitation and any waiting periods will not apply except to the extent that they would have applied had the covered employee maintained coverage.

If a covered employee fails to return to work upon the expiration of FMLA leave or fails to work for at least 30 days after his return, the *employer* may recover its contributions for coverage which it paid for the period of FMLA leave unless the covered employee's failure to return is due to a serious health condition that would otherwise entitle the covered employee to FMLA leave or other circumstances beyond the covered employee's control.

Commencement of FMLA leave is not a Qualifying Event for purposes of COBRA. However, a COBRA Qualifying Event will occur on the earlier of:

- the last date of the month after FMLA leave ends, unless the employee returns to work as required by the *employer*; or
- the date the employee notifies the employer that he will not return to work after FMLA leave ends.

An employee and his dependents may elect COBRA continuation coverage for an FMLA related Qualifying Event, even if he did not continue coverage during the FMLA leave.

OTHER LEAVES OF ABSENCE

If a covered employee takes an approved leave of absence (other than FMLA leave) or is laid off, he will not fail to qualify as an eligible employee solely because of his absence from work and may continue coverage for himself and his *dependents* under this *plan*. Coverage under this provision will end on the earliest of the following dates:

- the last day of the month after the layoff or leave of absence begins. (unless otherwise noted in collective bargaining agreement)

- the last day of the month the covered employee fails to make any payment for coverage when due.
- the date coverage would otherwise end in the case of an active *participant* or his *dependents*.

The covered employee is required to pay the entire cost of coverage provided under this provision. The beginning of the leave is also considered a Qualifying Event for purposes of the *plan's* COBRA Continuation section. COBRA elections must be made within the time frames described in that section and the maximum length of the continuation will be measured from the date the leave begins.

TERMINATION OF EMPLOYEE COVERAGE

An employee will no longer be a *participant* and all coverage under this *plan* will end on the earliest of the following dates:

- the date this *plan* terminates;
- the last day of the month the *participant* ceases to be an eligible employee;
- the last day of the month the *employer* amends the *plan* to eliminate coverage for the class of employee to which the *participant* belongs;
- the last day of the month any required contribution for coverage is not made when due; or
- the last day of the month the *participant* enters the Armed Forces on active duty, subject to the continuation and reinstatement provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

TERMINATION OF DEPENDENT COVERAGE

Coverage for a *dependent* of a *participant* will end on the earliest of the following dates:

- the date this *plan* terminates;
- the last day of the month the *participant's* coverage ends;
- the last day of the month any required contribution for coverage is not made when due;
- the last day of the month the *employer* amends the *plan* to eliminate coverage for the class of dependent to which the *covered person* belongs;

TERMINATION OF DEPENDENT COVERAGE

- the last day of the month in which the person is no longer an eligible *dependent* under the terms of the *plan*; or
- the last day of the month the *dependent* enters the Armed Forces on active duty.

Upon the loss of coverage, a *covered person* may be able to continue coverage. See the section of this *plan* describing COBRA Continuation Coverage. Please contact the *employer* for additional information.

COBRA CONTINUATION OF COVERAGE

A *covered person* who has a Qualifying Event will become a Qualified Beneficiary and may elect to continue coverage in accordance with the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, otherwise known as COBRA

All terms have the meanings defined throughout this section of the *plan* when they are capitalized.

QUALIFIED BENEFICIARIES

Qualified Beneficiaries are the Covered Employee if he loses coverage under this *plan* due to termination of employment (other than for gross misconduct) or reduction in hours worked and eligible Covered Dependents who were covered by this *plan* immediately prior to a Qualifying Event. In addition, a child born to, or placed for adoption with a Covered Employee during the period of COBRA continuation coverage is considered a Qualified Beneficiary.

QUALIFYING EVENT - EMPLOYEE

A Covered Employee will have the right to elect continuation coverage if he loses dental coverage under this *plan* because of:

1. a reduction in his hours of employment; or
2. the termination of his employment, for reasons other than gross misconduct.

WHAT IS COBRA?

COBRA is a federal law which applies to employers who have 20 or more employees and who sponsor group health plans. It requires these employers to offer employees and their family members who lose their health coverage under certain circumstances an opportunity to extend that coverage. This is called continuation coverage.

The information provided in this section of the *plan* summarizes this law.

QUALIFYING EVENT - DEPENDENTS

Each of the Covered Employee's Covered Dependents has the right to elect continuation coverage if he loses dental coverage under this *plan* because of:

1. a reduction in the Covered Employee's hours of employment;
2. the termination of the Covered Employee's employment, for reasons other than gross misconduct;
3. the death of the Covered Employee;
4. the Covered Employee's entitlement to Medicare;
5. the divorce or legal separation from the Covered Employee, in the case of the spouse; or
6. the Covered Employee's child no longer meeting the definition of a Covered Dependent.

NOTIFICATION

The Covered Employee or the Covered Employee's spouse has the responsibility to notify the *plan administrator* of divorce, legal separation or a child losing Covered Dependent status. Written notice of the Qualifying Event must be given to the *plan administrator* within 60 days of the Qualifying Event. Additionally, a Qualified Beneficiary disabled under Titles II or XVI of the Social Security Act must give written notice to the *plan administrator* within 60 days of the date of the Social Security Administration's determination of disability.

NOTICE AND ELECTION

Within 14 days of the date it receives notice of a Qualifying Event, the *plan administrator* will give written election notice to Qualified Beneficiaries of the right to continuation of coverage. The notice will state the amount of premium required for the continuation of coverage. If the Qualified Beneficiary wants continuation coverage, then he must complete and return the election notice within 60 days of the later of:

1. the date the coverage would otherwise have ended; or
2. the date of the notice informing the person of the right to continue.

If a person elects COBRA continuation, he must pay the premium for the "initial premium months" by the 45th day after the date of the election. The initial premium months are the months that end on or before the 45th day after the date of the election. COBRA coverage will become effective back to the date of the loss of coverage upon timely receipt of the initial premium.

All other premium payments are due on the 1st of the month for which continuation coverage is provided, subject to a 30-day grace period. Claims incurred during the grace period will not be paid unless and until the required premium is timely received.

DURATION OF COVERAGE

If the Qualified Beneficiary is a former Covered Employee or Covered Dependent and the Qualifying Event is termination of employment (for reasons other than gross misconduct) or reduction of hours, then:

1. the maximum period of continuation of coverage is 18 months from the date of the Qualifying Event; however,
2. if the Qualified Beneficiary is also disabled on the date of the Qualifying Event or within 60 days thereafter as determined under Titles II or XVI of the Social Security Act, then the maximum period of continuation coverage for the disabled Qualified Beneficiary and members of his family who are also Qualified Beneficiaries is 29 months from the date of the Qualifying Event, provided that the *plan administrator* is notified of the determination during the initial 18 month period and within 60 days of the determination.

If the Qualified Beneficiary is a Covered Dependent and:

1. the Qualifying Event is the Covered Employee's death, divorce, legal separation, entitlement to Medicare benefits or the end of the Covered Dependent child's eligibility under this *plan*, then the maximum period of continuation coverage is 36 months from the date of the Qualifying Event; however;
2. if a second Qualifying Event occurs during the 18 months that the Covered Dependent has continuation of coverage as a result of the Covered Employee's termination of employment (for reasons other than gross misconduct) or reduction of hours, then the maximum period of continuation coverage is 36 months from the date of the first Qualifying Event; or
3. in the case of a Qualifying Event which is the Covered Employee's termination of employment (for reasons other than gross misconduct) or reduction of hours which occurs within 18 months after the date the employee became entitled to Medicare, the maximum period of continuation coverage for Qualified Beneficiaries other than the Covered Employee is 36 months after the date the employee became entitled to Medicare.

Continuation coverage may terminate before the end of the maximum period of continuation of coverage as soon as any of the following events occurs:

1. the required monthly contribution for continuation coverage is not received on a timely basis;
2. a Qualified Beneficiary first becomes covered after the date of his election under any group health plan which does not contain any exclusion or limitation that applies to any preexisting condition of the Qualified Beneficiary;
3. the date the Qualified Beneficiary first becomes entitled to Medicare after the date of his election;
4. in the case of any Qualified Beneficiary who is entitled to a maximum continuation period of 29 months due to his disability or that of another Qualified Beneficiary, the first day of the month following 30 days after the date the Social Security Administration determines that the formerly disabled Qualified Beneficiary is no longer disabled; or
5. the date the *employer* ceases to provide any group health plan for any employee.

Benefits under continuation coverage will be paid according to the provisions and limitations of the *plan* in force on the date services are rendered.

COBRA FOR TAA ELIGIBLE PERSONS

Tax Credits: A former employee who properly elects COBRA and is an eligible recipient of trade adjustment assistance (TAA) under the Trade Act of 2002 may be entitled to a tax credit or advance payment of 65% of the premiums for COBRA or other qualified health insurance for himself and his dependents. More information about how to apply for and receive the credit or advance payment is available from the Health Care Tax Credit Customer Service Center at 1-866-628-4282.

Second Election Period: A former employee who is entitled to elect COBRA but does not do so during the regular election period will have a second COBRA election period if:

- the employee is eligible for the TAA tax credit; and
- the first qualifying event was loss of a job that resulted in his TAA eligibility.

The second election period begins on the first day of the month in which the employee becomes eligible for trade adjustment assistance and ends:

- 60 days later; or
- 6 months after the initial loss of coverage;

whichever comes first.

Coverage will begin on the first day of the second election period. The time between the loss of coverage and the start of the second election period will not be counted when determining whether there has been a break in coverage for purposes of the *plan's* exclusion for preexisting conditions.

DENTAL BENEFITS

COVERED CHARGES

This *plan* provides dental benefits for *covered charges*. *Covered charges* are the actual cost charged to a *covered person* for *medically necessary* dental services and supplies or specified routine care. In addition, to be a *covered charge*, a charge must be incurred for services and supplies which are:

- provided by or under the direction of a *physician* or *dentist*, except as specifically provided;
- started and completed while a *covered person* is enrolled in this *plan*;
- specifically listed in this *plan* as a covered dental service or supply; and
- not excluded or limited by any provision of this *plan*.

Class A Services: Type I, Preventive and Diagnostic Dental Procedures

The limits on Class A services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

- (1) Routine oral exams. This includes the cleaning and scaling of teeth. Limit of 2 per Covered Person each Calendar Year paid at 100%, services in excess of the 2 per Covered Person per Calendar Year will be covered at 50%.
- (2) One bitewing x-ray series per Calendar Year covered at 100%, services in excess of the one per Covered Person per Calendar Year will be covered at 50%.

- (3) One full mouth x-ray every Calendar Year covered at 100%, services in excess of the one per Covered Person per Calendar Year will be covered at 50%.
- (4) One fluoride treatment for per Calendar Year, covered at 50%
- (5) Space maintainers covered at 50%.
- (6) Emergency palliative treatment for pain, covered at 50%.
- (7) Topical application of Sealant(s), covered at 50%.

Class B Services: Type II
Basic Dental Procedures-Class B Covered at 50%

- (1) Dental x-rays not included in Class A.
- (2) Oral surgery. Oral surgery is limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than 1/4 inch.
- (3) Amalgam, Composite Resin, Acrylic, Plastic, Silicate cement synthetic or porcelain restorations.
- (4) Endodontics (root canals).
- (5) Extractions. This service includes local anesthesia and routine post-operative care.
- (6) Recementing bridges, crowns or inlays.
- (7) General anesthetics, upon demonstration of Medical Necessity.
- (8) Antibiotic drugs.

Class C Services: Type III
Major Dental Procedures-Class C Covered at 50%

- (1) Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.
- (2) Installation of crowns.
- (3) Installing precision attachments for removable dentures.

- (4) Addition of clasp or rest to existing partial removable dentures.
- (5) Initial installation of fixed bridgework to replace one or more natural teeth.
- (6) Repair of crowns, bridgework and removable dentures.
- (7) Rebasing or relining of removable dentures.
- (8) Endodontics (Root canals).
- (9) Periodontics (Gum disease).
- (10) Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this item will apply only if one of these tests is met:
 - (a) The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable.
- (11) Implants including any appliances and/or crowns and the surgical insertion or removal of implants.

**Class D Services: Type IV
Orthodontic Treatment and Appliances-Class D Covered at 50%**

This is treatment to move teeth by means of appliances to correct a handicapping malocclusion of the mouth.

These services are available for covered Employees and Dependents and include preliminary study, including x-rays, diagnostic casts and treatment plan, active treatments and retention appliance.

Payments for comprehensive full-banded orthodontic treatments are made in installments.

EXCLUSIONS

A charge for the following is not covered:

- (1) **Administrative costs.** Administrative costs of completing claim forms or reports or for providing dental records.

- (2) **Before coverage.** Care, treatment or supplies for which a charge was incurred before a person was Covered under this Plan.
- (3) **Broken appointments.** Charges for broken or missed dental appointments.
- (4) **Crowns.** Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.
- (5) **Cosmetic Procedures** – Any treatment, care or surgery which is performed solely for cosmetic purposes and results in no functional improvement is not covered under the Plan (i.e. Bleaching Teeth, Veneers, Acid Etch, etc)
- (6) **Customized Dental Work** – Services, supplies and appliances which, by accepted standards of dentistry are more elaborate than those customarily employed, including specialized techniques or other personalization or characterization of dentures.
- (7) **Excess charge.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the charge.
- (8) **Criminal behavior.** Charges for services received as a result of Injury or Sickness caused or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, assault or other wrongful behavior, or by participating in a riot or public disturbance.
- (9) **Prosthetic Dental Appliances Installed after Termination** – Charges for any prosthetic dental appliances finally installed or delivered more than 90 days after such person’s termination of coverage under this Plan.
- (10) **Government.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
- (11) **Hygiene.** Oral hygiene, plaque control programs or dietary instructions.
- (12) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
- (13) **No listing.** Services which are not included in the list of covered dental services.

ABOUT THIS SECTION

This section lists supplies, services and expenses for which the plan will not pay.

The items listed here are in addition to any exclusions listed in the section of this plan on covered charges.

- (14) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.
- (15) **Not Medically or Dentally Necessary.** Care and treatment that is not Medically or Dentally Necessary.
- (16) **Occupational.** Care and treatment of an Injury or Sickness that, in either case, is occupational -- that is arises from work for wage or profit, including self-employment.
- (17) **Orthognathic surgery.** Surgery to correct malpositions in the bones of the jaw.
- (18) **Personalization.** Personalization of dentures.
- (19) **Plan design.** Charges excluded or limited by the Plan design as stated in this document.
- (20) **Relative.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.
- (21) **Replacement.** Replacement of lost or stolen appliances.
- (22) **Self-inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (23) **Splinting.** Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.
- (24) **TMJ.** All diagnostic and treatment services related to the treatment of jaw joint problems including temporomandibular joint (TMJ) syndrome.
- (25) **War.** Any loss that is due to a declared or undeclared act of war.

BENEFIT DETERMINATION

COORDINATION OF BENEFITS

Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance up to each one's plan formula minus whatever the primary plan paid. If this plan is primary, the plan shall pay regular benefits. If this plan is secondary; this plan will pay 50% of the balance (unless it is for certain preventative services then the plan shall pay 100%) due after the primary carrier has made the payment. Remaining balances are the responsibility of the employee.

Benefit plan. This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

- (1) Group or group-type plans, including franchise or blanket benefit plans.
- (2) Kent County group health plans.
- (3) Group practice and other group prepayment plans.
- (4) Federal government plans or programs. This includes Medicare.
- (5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
- (6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable charge. For a charge to be allowable it must be a charge and at least part of it must be covered under this Plan.

ABOUT THIS SECTION

If a person is covered under two or more group dental plans, one plan (called the "primary" plan) will pay its benefits as if no other coverage existed. The other Plans (called "secondary" Plans) will reduce their benefits based on what the primary Plan has paid.

This section describes the rules this Plan will use to decide if it is primary or secondary. It also describes how this Plan will reduce its benefits when it is secondary.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

Benefit plan payment order. When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules.

- (1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
- (2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:
 - (a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").
 - (b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
 - (c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
 - (d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:
 - (i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
 - (ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.

- (e) When a child's parents are divorced or legally separated, these rules will apply:
 - (i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
 - (ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.
 - (iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.
 - (iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.
 - (v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.
 - (f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of allowable charges when paying secondary.
- (3) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of

or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

ADMINISTRATIVE PROVISIONS

CONDITIONS FOR PAYMENT OF BENEFITS

If a *covered person* receives dental treatment or service, the *plan* will pay benefits for *covered charges*:

1. at the payment percentage(s) indicated; and
2. to the maximum benefit limits.

PAYMENT OF BENEFITS

To qualify for payment of benefits a *covered person* must:

1. be covered on the date he receives treatment or services; and
2. satisfy the requirements listed in the Claims section of this *plan*.

ABOUT THIS SECTION

The Administrative Provisions section of this *plan* includes:

- the conditions for payment of benefits.
- the procedure for filing claims.
- a person's rights if he disagrees with a decision about his right to *plan* benefits.
- the *plan's* right to recover overpayments.
- the *employer's* right to amend or terminate the *plan*.

BENEFIT TERMS

Benefits payable, as described in this section, are subject to all terms, conditions, limitations and exclusions in the *plan*, including Coordination With Other Benefits.

CLAIMS

All terms have the meanings defined throughout this section of the *plan* when they are capitalized.

CLAIM FORMS

Claim forms can be obtained from the *Human Resources Department*.

**Kent County
Human Resources Department
Dental Reimbursement Claim Form**

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them. If you should have to file a claim.

When a Covered Person has a Claim to submit for payment that person must:

- (1) Obtain a Claim form from Human Resources or the Claims Administrator.
- (2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.
- (3) Have the Dentist complete the provider's portion of the form.
- (4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:
 - Name of Plan
 - Employee's name
 - Name of patient
 - Name, address, telephone number of the provider of care
 - Diagnosis
 - Type of services rendered, with diagnosis and/or procedure codes
 - Date of services
 - Charges
- (5) Send the above to the Claims Administrator at this address:

Professional Benefits Services, Inc.
2959 Lucerne Dr SE, Suite 205
Grand Rapids, Michigan 49546
616-285-2480

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 30 days of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

- (a) it's not reasonably possible to submit the claim in that time; and
- (b) the claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

CLAIMS PROCEDURE

Following is a description of how the Plan processes Claims for benefits. A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, that complies with the Plan's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different kinds of Claims and each one has a specific timetable for either approval, payment, request for further information, or denial of the Claim. If you have any questions regarding this procedure, please contact the Plan Administrator.

The definitions of the types of Claims are:

URGENT CARE CLAIM

A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:

Notification to claimant of benefit determination	72 hours
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Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:

Notification to claimant, orally or in writing	24 hours
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Response by claimant, orally or in writing	48 hours
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Benefit determination, orally or in writing	48 hours
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Ongoing courses of treatment, notification of:

Reduction or termination before the end of treatment	72 hours
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Determination as to extending course of treatment	24 hours
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If there is an adverse benefit determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method.

POST-SERVICE CLAIM

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care; in other words, a Claim that is a request for payment under the Plan for covered medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of benefit determination	30 days
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Extension due to matters beyond the control of the Plan	15 days
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Extension due to insufficient information on the Claim	15 days
Response by claimant following notice of insufficient information	45 days
Review of adverse benefit determination	30 days per benefit appeal

Notice to claimant of adverse benefit determinations

Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of any adverse benefit determination. The notice will state, in a manner calculated to be understood by the claimant:

- (1) The specific reason or reasons for the adverse determination.
- (2) Reference to the specific Plan provisions on which the determination was based.
- (3) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.
- (4) A description of the Plan's review procedures, incorporating any voluntary appeal procedures offered by the Plan, and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an adverse benefit determination on review.
- (5) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office."
- (6) If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.

- (7) If the adverse benefit determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

APPEALS

When a claimant receives an adverse benefit determination, the claimant has 180 days following receipt of the notification in which to appeal the decision. A claimant may submit written comments, documents, records, and other information relating to the Claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

- (1) was relied upon in making the benefit determination;
- (2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
- (3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- (4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the

individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

Voluntary appeals, including voluntary arbitration

During voluntary dispute resolution, any statute of limitations or other defense based on timeliness is tolled during the time any voluntary appeal is pending.

The Plan waives any right to assert that a claimant has failed to exhaust administrative remedies because he or she did not elect to submit a benefit dispute to the voluntary appeal provided by the Plan. A claimant may elect a voluntary appeal after exhaustion of appeals of an adverse benefit determination as explained in the section above, entitled, "Appeals." However, this voluntary appeal may be conducted as one of the two appeals available to the claimant.

The Plan will provide to the claimant, at no cost and upon request, sufficient information about the voluntary appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal. This information will include a statement that the decision will have no effect on the claimant's rights to any other benefits under the Plan; will list the rules of the appeal; state the claimant's right to representation; enumerate the process for selecting the decision maker; and give circumstances, if any, that may affect the impartiality of the decision maker.

The claimant will be notified that fees or costs will be imposed on the claimant as part of the voluntary level of appeal.

OTHER IMPORTANT PROVISIONS

PLAN DOCUMENT

The *employer* has established this *plan* pursuant to certain legal documents maintained by the *employer* called the Plan Document. This booklet is intended to summarize the Plan Document and describe the benefits available under the *plan*. While the *employer* believes that the descriptions in this booklet are accurate, if there is any discrepancy between this booklet and the Plan Document, the terms of the Plan Document will control.

The *employer*, acting as *plan administrator*, has the right to interpret and construe the terms and provisions of this *plan* and determine eligibility for coverage and the amount and manner and time of payment of benefits under the *plan*. It has the right to resolve any conflicts or ambiguities in the *plan* and the right to determine any issues of fact or law which may bear on the *plan's* obligation to pay benefits. Benefits under this *plan* will be paid only if the *plan administrator* decides in its discretion that the claimant is entitled to them.

AMENDMENT AND TERMINATION

The *employer* has the right, in its sole discretion, from time to time, to amend this *plan* by written amendment signed by the Plan Administrator or other authorized officer of the *employer*. The effective date of any such amendment shall be the date it is signed or such other date as the amendment may specify. The *employer* will notify *participants* of amendments.

The *employer* has the right to terminate or suspend this *plan* at any time, in its entirety or in part. The *plan* will pay no benefits for expenses incurred on or after the effective date of termination.

Except as described in this provision, no act or statement of any person shall have the effect of amending the *plan*, creating coverage or of waiving any of its provisions or requirements.

PARTICIPANT CONTRIBUTIONS

The *employer* may require *participants* to contribute toward the cost of their coverage. The *employer* may determine the amount of the required contributions from time to time at its discretion and will advise *participants* in advance of any changes in such amount.

DUE DATE OF PARTICIPANT CONTRIBUTIONS

The *employer* may require employees to contribute to the cost of coverage for themselves and their *dependents*. For active *participants* and those who are on paid leave, the *employer* will automatically deduct the amount of the required contribution from the employee's pay. For *participants* who are on unpaid leave or who are otherwise eligible for continued coverage (other than COBRA coverage), the employee must pay the required contribution by the 19th of the

month for the following month's coverage. Persons covered under the COBRA Continuation section of this *plan* must pay required contributions as described in that section.

PLAN FUNDING

From time to time and at its discretion, the *employer* may determine the funding method for benefits under this *plan* which may include, without limitation, policies of insurance, self-funding and partial self-funding. Currently, the *employer* self-funds and pays all benefits due under this *plan* out of its general assets including *employer* and employee contributions.

Employee contributions are used exclusively for *plan* benefits and are deemed to be expended before any *employer* contributions.

CONFIDENTIAL MEDICAL INFORMATION

Each *covered person* acknowledges that the *plan administrator* and *claims administrator* may review and disclose any and all confidential medical information to the extent reasonably necessary and appropriate to the performance of their respective duties under this *plan* and each *covered person*, by accepting coverage under this *plan*, consents to such review and disclosure.

LIMITS OF LIABILITY

No person shall have any claim against the *employer*, the *plan* or the *plan administrator* except for the amount of regular *plan* benefits due under this *plan*.

No person shall have any claim against the *employer*, the *plan*, the *plan administrator* or their appointees arising out of injuries caused by any provider.

This *plan* does not create a contract of employment between the *employer* and any employee nor does it affect the status of any person as an employee-at-will.

CONSTRUCTION

Words used in this *plan* which take the masculine form shall be construed to include the feminine form. Similarly, words used in the singular or plural shall be construed as including the plural or singular respectively as circumstances and context may require.

Section and paragraph headings are included for ease of reference and do not explain, limit or expand any provision in this *plan*.

The *plan* shall be construed and administered to comply in all respects with applicable federal law.

EFFECTIVE DATE

The Effective Date of this amendment and restatement of the *plan* is January 1, 2015.

PRIVACY OF HEALTH INFORMATION

The plan sponsor performs various activities on behalf of the *plan* related to payment of benefits and *plan* operations.

As used in this section:

“Payment” includes activities undertaken by the *plan* to determine eligibility and provide benefits; to conduct utilization review, precertification, concurrent care and retrospective review activities; to bill and collect premiums; to coordinate benefits and enforce its reimbursement and subrogation rights; and to obtain payment from stop-loss insurance.

“Plan Operations” includes underwriting, premium rating, and other activities relating to the creation or maintenance of the *plan*; the acquisition and maintenance of stop-loss insurance; conducting or arranging for medical review, legal services and auditing; business planning and development relating to the management and operation of the *plan*; and conducting the general business activities of the *plan*.

“Treatment” includes the provision, coordination of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; or the referral of a patient for health care from one health care provider to another.

“Health Information” means information about a *covered person* that the *plan* creates, receives or maintains; and that relates to the person’s physical or mental condition or payment for health care provided to that person; and that can reasonably be used to identify that person.

“Plan Sponsor” means XYZ Company.

"Privacy Rule" means the regulations found at 45 C.F.R. parts 160 and 164.

“Covered Person” means a person who is currently or was previously covered under the *plan*.

USES AND DISCLOSURES

The *plan* may disclose Health Information about Covered Persons to the Plan Sponsor for purposes of Treatment, Payment and Plan Operations. The *plan*’s Notice of Privacy Practices (Notice) describes the permitted and required uses and disclosures of Health Information by the Plan Sponsor. A copy of the Notice is given to all *participants*. In addition, anyone can receive a copy of the Notice by requesting one in writing from the *plan administrator*.

The Plan Sponsor will:

- not use or further disclose the information other than as permitted or required by the plan documents or as required by law;
- ensure that any agents, including a subcontractor, to whom it provides Health Information received from the *plan* agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
- not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- report to the *plan* any use or disclosure of the information that is inconsistent with the uses or disclosures provided of which it becomes aware;
- make available Health Information as required by section 164.524 of the Privacy Rule;
- permit a Covered Person to amend his Health Information and incorporate any amendments to his Health Information as required by section 164.526 of the Privacy Rule;
- make available to a Covered Person the information required to provide an accounting of disclosures as required by section 164.528 of the Privacy Rule;
- make its internal practices, books, and records relating to the use and disclosure of Health Information received from the *plan* available to the Secretary of Health and Human Services for purposes of determining the *plan's* compliance with the privacy requirements of HIPAA;
- if feasible, return or destroy all Health Information received from the *plan* that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- ensure that adequate separation between the *plan* and Plan Sponsor is established.

SEPARATION BETWEEN PLAN AND PLAN SPONSOR

The Plan Sponsor must certify to the *plan* that the *plan* documents have been amended to incorporate the provisions set forth above. The *plan* will release Health Information to the Plan Sponsor only upon receipt of this certification.

Only the following employees of the Plan Sponsor may have access to a Covered Person's Health Information:

Human Resources Technician
Human Resources Specialist I
Human Resources Specialist II
Senior Human Resources Specialist
Human Resources Manager

However, no employee will have access to any portion of a Covered Person's Health Information unless access is needed to perform that employee's duties with respect to the *plan*.

FILING COMPLAINTS

If a Covered Person believes that the *plan* or Plan Sponsor has not complied with the requirements set forth in this section, the person may file a written complaint as described in the *plan's* Notice of Privacy Practices.

GLOSSARY OF DEFINED TERMS

This section defines certain terms used in this *plan*. When these terms appear in the *plan*, they are in italics. Other terms are defined in the section of the *plan* in which they are primarily used.

Active Employee	An employee who is on regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis.
Actively at Work	An employee is actively at work if he is regularly performing all the customary duties of his job with the <i>employer</i> . He is considered actively at work on any day when he is not normally scheduled to work (such as a weekend or holiday) or on which he is absent from work solely because of his medical condition provided he was actively at work on his last regularly scheduled work day.
Calendar Year	January 1 st through December 31 st of the same year.
Child	A child is a <i>participant's</i> natural child or legally adopted child (including a child placed with a <i>participant</i> for adoption) or resident stepchild. It also includes a <i>participant's</i> legal ward or foster child who resides in the <i>participant's</i> household and who the <i>participant</i> legally claims as a <i>dependent</i> for federal income tax purposes. Any child who does not reside with a <i>participant</i> but otherwise qualifies as a <i>dependent</i> child is eligible for coverage under this plan.
Claims Administrator	Any entity authorized by the <i>employer</i> to process claims for benefits under the <i>plan</i> . The <i>claims administrator</i> is not an insurer of benefits or a fiduciary of the <i>plan</i> ; it has no discretionary authority with respect to matters of eligibility or benefits; it is not responsible for <i>plan</i> financing and does not guarantee <i>plan</i> benefits.
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Cosmetic Dentistry	Dentally unnecessary procedures.
Covered Charges	<p>The actual cost charged to a <i>covered person</i> for <i>medically necessary</i> care of an <i>illness</i> or <i>injury</i> or for specified routine care, but only to the extent that the actual cost charged does not exceed <i>charges</i>. In addition, to be a <i>covered charge</i>, a charge must be incurred for services and supplies which are:</p> <ol style="list-style-type: none"> 1. prescribed by a <i>dentist</i>, 2. provided to a <i>covered person</i> while covered under the <i>plan</i>; 3. specifically listed in this <i>plan</i> as covered; and 4. not excluded or limited by any provision of this <i>plan</i>.
Covered Person	An Employee or Dependent who is covered under this <i>plan</i> .
Dental Hygienist	A person who has been trained to clean teeth and provide additional services and information on the prevention of oral disease.
Dentist	A duly licensed doctor of dental surgery (DDS) or doctor of dental medicine (DMD).
Dependent	<p>A <i>participant's</i>:</p> <ol style="list-style-type: none"> 1. legal <i>spouse</i>; or 2. <i>child</i>, under the Limiting Age. <p>The term <i>dependent</i> does not include any person who is a member of the armed forces of any country.</p> <p>The Limiting Age is the date the <i>child</i> becomes 26 years old.</p>
Employee	A person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.
Employer	County of Kent.

Enrollment Date	The first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.
ERISA	The Employee Retirement Income Security Act of 1974, as amended.
Experimental or Investigational	<p>Any treatment, procedure, service, supply, device or drug:</p> <ol style="list-style-type: none"> 1. with respect to which there is no general consensus among knowledgeable <i>dentists</i> that it is safe and effective; or 2. that is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with the standard means of treatment or diagnoses; or 3. which is subject to review and approval by the treating facility's Institutional Review Board or other body serving a similar function; or 4. that is regarded as experimental or investigational; or 5. that does not meet the standards and guidelines established by the American Dental Association.
Family Unit	The covered Employee and the family members who are covered as Dependents under the Plan.
Foster Child	<p>An child under the limiting age shown in the Dependent Eligibility Section of this Plan for whom a covered Employee has assumed a legal obligation. All of the following conditions must be met: the child is being raised as the covered Employee's; the child depends on the covered Employee for primary support.</p> <p>A covered Foster Child is <u>not</u> a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural</p>

parent(s) may exercise or share parental responsibility and control.

Immediate Family

The patient's spouse and the parents, siblings and *children* of the patient and their spouses.

Injury

A bodily injury occurring at a definite time and place and resulting from a sudden and unforeseen event, including intentionally self-inflicted injuries.

Legal Guardian

A person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Medically Necessary or Medical Necessity

Services or supplies, provided by a covered provider, which are required for treatment of *illness, injury, diseased condition, or impairment*, and are:

1. consistent with the patient's diagnosis or symptoms;
2. appropriate treatment, according to generally accepted standards of medical or dental practice;
3. not provided mainly as a convenience to the patient, provider or any other person;
4. not *experimental or investigational*; and
5. not excessive in scope, duration, or intensity needed to provide safe, adequate, and appropriate treatment. Any services or supplies provided at a particular facility will not be considered medically necessary if the patient's symptoms or condition indicate that it would be safe to provide the service or supply in a less comprehensive setting.

The fact that any particular provider may prescribe, order, recommend, or approve a service, supply, or level of care does not, of itself, make that treatment medically necessary or make the charge a *covered charge*.

No-Fault Auto Insurance	The basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.
Participant	An employee or former employee of the <i>employer</i> who is covered under this <i>plan</i> .
Physician	A duly licensed doctor of medicine (MD) or doctor of osteopathy (DO).
Plan	County of Kent Dental Benefit Plan.
Plan Administrator	County of Kent.
Reasonable and Customary Charges	<p>The <i>reasonable and customary charge</i> is the lower of:</p> <ul style="list-style-type: none"> • the amount generally charged by the provider of the services or supplies for the same or similar services or supplies; or • the amount charged by providers in the same geographic area for similar services and supplies provided to individuals with similar medical conditions. This amount is set by the <i>plan administrator</i> at the 90th percentile for such fees based on standard data bases and other information used by the <i>plan administrator</i>.
Spouse	The person who is recognized as a <i>participant's</i> husband or wife under the laws of the state where the <i>participant</i> lives.
Total Disability (Totally Disabled)	In the case of a Dependent child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and gender in good health.

SUMMARY PLAN DESCRIPTION AND STATEMENT OF RIGHTS

Type of Administration

The Plan is a self-funded 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 and contributions made by covered Employees. The Plan is not insured.

Plan Name: County of Kent Dental Plan

Plan Number: 502

Tax ID Number: 38-6004862

Plan Effective Date: January 1, 2015

Plan Year Ends: December 31

Employer Information: County of Kent
300 Monroe Ave. NW
Grand Rapids, MI 49503
616-632-7440

Plan Administrator: County of Kent
300 Monroe Ave. NW
Grand Rapids, MI 49503
616-632-7440

Named Fiduciary County of Kent
300 Monroe Ave. NW
Grand Rapids, MI 49503

Agent for Service of Legal Process: County of Kent
300 Monroe Ave. NW
Grand Rapids, MI 49503

Claims Administrator: Professional Benefits Services, Inc.
2959 Lucerne Dr. SE, Suite 205
Grand Rapids, MI 49546
616-285-2480

ERISA Rights Statement:

The following information, together with the other information contained in this document, comprise the Summary Plan Description under the Employee Retirement Income Security Act of 1974 (ERISA).

As a participant in this plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as work sites 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.

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 administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the 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 a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If 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. 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 any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.