Plan Document and Summary Plan Description for the Cherokee County Dental Plan

- Dental Benefits

Amended and Restated: 07/01/2021

Administered by:

CRESCENT HEALTH SOLUTIONS

Plan Sponsor and Administrator

Cherokee County
75 Peachtree Street
Murphy, NC 28906
828-837-2735

Plan Year

The Plan Year is July 1 through June 30

Deductible and Out of Pocket Year

July 1 – June 30

Dental Plan Claims Administrator/Dental COBRA Administrator

Crescent Health Solutions, Inc.
1200 Ridgefield Blvd.
Suite 215
Asheville, NC 28806
828-670-9145
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Introduction

This booklet describes your dental plan benefits and serves as the Summary Plan Description (SPD) and Plan document for the Cherokee County Dental ("the Plan").

This document sets forth the provisions *of the Plan that provide for payment or reimbursement of Plan benefits.*

This document contains information on the standard provisions and administration of the Plan. From time to time, applicable law may require the County to temporarily make adjustments to how it administers the Plan due to unforeseen circumstances, such as public health emergencies, natural disasters or other emergency situations. In those situations, the County intends to comply with all applicable legal requirements, including deadline extensions, maintenance to benefits and other changes to coverage. Unless they are addressed in specific plan amendments, any such changes required by law are incorporated herein by reference to the extent necessary for the Plan to be in compliance.

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

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

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Plan Overview

Your Eligibility

You are eligible for benefits if you are:

- A full-time active employee normally scheduled to work a minimum of 30 hours per week;
- Retired Employee of the County up to age 65 or until eligible for Medicare with 30 years of service;
- On the regular payroll of the County; and
- In a class of employees eligible for coverage.

Unless otherwise communicated to you in writing by the County, the following individuals are not eligible for benefits: part-time employees, employees of a temporary or staffing firm, payroll agency or leasing organization, independent contractors and other individuals who are not on the County payroll, as determined by the County, without regard to any court or agency decision determining common-law employment status.

Eligible Dependents

You may enroll your eligible dependents on your coverage. Your eligible dependents include:

- your legal spouse;
- your child under age 26 regardless of financial dependency, residency with you, marital status, or student status; or
- your unmarried child of any age who is principally supported by you and who is not capable of self-support due to a physical or mental disability that began while the child was covered by the Plan.

“Principally supported by you” means that the child is dependent on you for more than one-half of his or her support, as defined by Code Section 152 of the Internal Revenue Code.

For purposes of the Plan, your child includes:

- your biological child;
- your legally adopted child (including any child lawfully placed for adoption with you);
- your stepchild;
- a foster child who has been placed with you by an authorized placement agency or by judgment decree or other court order;
- a child for whom you are the court-appointed legal guardian;
- an eligible child for whom you are required to provide coverage under the terms of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN).

An eligible dependent does not include:

- a person enrolled as an employee under the Plan;
- any person who is in active military service;
- a former Spouse; or

- a person who is covered as a dependent of another employee covered under the Plan. If you and your spouse are both employed by the County, each of you may elect your own coverage (based on your own eligibility for benefits) or one of you may be enrolled as a dependent on the other's coverage, but only one of you may cover your dependent children.

In addition, an eligible dependent who lives outside the U.S. cannot be covered as your dependent, unless the dependent has established his or her primary residence with you.

It is your responsibility to notify the County if your dependent becomes ineligible for coverage.

Proof of Dependent Eligibility

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

When Coverage Begins

For You

Your health care coverage begins first day of the month following a full calendar month of employment and after you meet all eligibility requirements.

If you terminate employment and are subsequently rehired, you will be treated as a new employee and will need to satisfy all eligibility requirements in order to be covered under the Plan. However, if you return to work and were enrolled in COBRA Continuation Coverage immediately prior to your rehire date, you will be covered under the Plan as of your rehire date.

For Your Dependents

Coverage for your eligible dependents begins on the same day as your initial eligibility provided you timely enroll your dependents in coverage.

If you acquire a new dependent through marriage, birth, adoption or placement for adoption, you can add your new dependent to your coverage as long as you enroll the dependent within 31 days of the date on which they became eligible. If you wait longer than 31 days, you may be required to wait until the Plan's next open enrollment period to enroll your new dependent for coverage.

A newborn child born while you are enrolled for dental coverage will not automatically be enrolled in the Plan. Coverage will be effective with the newborn's date of birth, provided the child is enrolled within 31 days of birthYour Cost for Coverage

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

You pay your portion of this cost through pre-tax payroll deductions taken from your pay each pay period. Your actual cost is determined by the coverage you select and the number of

dependents you cover. You must elect coverage for yourself in order to cover your eligible dependents.

Enrolling for Coverage

New Hire Enrollment

As a newly eligible employee, you will receive enrollment information when you first become eligible for benefits. To enroll in dental coverage, you will need to make your coverage elections by the deadline shown in your enrollment materials. When you enroll in the Plan, you authorize the County to deduct any required premiums from your pay.

The elections you make will remain in effect until the next June 30, unless you have a qualifying change in status. After your initial enrollment, you will enroll during the designated annual open enrollment period. If you do not enroll for coverage when initially eligible, you will only be eligible for the default coverages designated by the Plan Administrator, as shown in your enrollment materials.

You will automatically receive identification (ID) cards for you and your eligible dependents when your enrollment is processed.

Late Entrant

Your enrollment will be considered timely if your completed enrollment form is received within 31 days after you become eligible for coverage. You will be considered a “late entrant” if:

- You elect coverage more than 31 days after you first become eligible
- You again elect coverage after canceling

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

Annual Open Enrollment

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

Effect of Section 125 Tax Regulations on this Plan

It is intended that this Plan meets the requirements of the Internal Revenue Code Section 125 and the regulations thereunder and that the qualified benefits which you may elect are eligible for exclusion from income. The Plan is designed and administered in accordance with those regulations. This enables you to pay your share of the cost for coverage on a pre-tax basis. Neither the County nor any fiduciary under the Plan will in any way be liable for any taxes or other liability incurred by you by virtue of your participation in the Plan.

Because of this favorable tax-treatment, there are certain restrictions on when you can make changes to your elections. Generally, your elections stay in effect for the Plan Year and you can make changes only during each annual open enrollment. However, at any time throughout the year, you can make changes to your coverage within 31 days following:

- The date you have a qualifying change in status as described below;
- The date you meet the Special Enrollment Rights criteria described below.

Qualifying Change in Status

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

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

- your marriage;
- the birth, adoption, or placement for adoption of a child;
- your death or the death of your spouse or other eligible dependent;
- your divorce, annulment, or legal separation;
- a change in a dependent child's eligibility due to age or eligibility for other coverage;
- a change in employment status for you or your spouse that affects benefits (including termination or commencement of employment, strike or lockout, or commencement of or return from an unpaid leave of absence);
- a change in your County work location or home address that changes your overall benefit options and/or prices;
- employee's spouse's open enrollment period differs and employee needs to make changes to account for other coverage;
- a significant change in coverage or the cost of coverage;
- a reduction or loss of your or a dependent's coverage under this or another plan;
- a court order, such as a QMCSO or NMSN, that mandates coverage for an eligible dependent child;

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

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

Contact the Plan Administrator if you have questions about when you can change your elections.

Special Enrollment Rights

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However,

you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

You or an affected eligible dependent may also enroll in coverage if eligibility for coverage is lost under Medicaid or the Children's Health Insurance Program (CHIP), or if you become eligible for premium assistance under Medicaid or CHIP. You must enroll under this Plan within 60 days of the date you lose coverage or become eligible for premium assistance.

This "special enrollment right" exists even if you previously declined coverage under the Plan. You will need to provide documentation of the change. Contact the Plan Administrator to determine what information you will need to provide.

When Coverage Ends

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

Coverage for your covered dependents ends when your coverage ends or, if earlier, on the date your dependent is no longer eligible for coverage under the Plan.

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

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

Cancellation of Coverage

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

Rescission of Coverage

Coverage under the Plan may be rescinded (canceled retroactively) if you or a covered dependent performs an act, practice or omission that constitutes fraud, or you make an intentional misrepresentation of material fact as prohibited by the terms of the Plan. A rescission of coverage is an adverse benefit determination that you may dispute under the Plan's claims and appeals procedures. If your coverage is being rescinded due to fraud or intentional misrepresentation of material fact, you will receive at least 30 days' advance written notice of the rescission. This notice will outline your appeal rights under the Plan. Benefits under the Plan that qualify as "excepted benefits" under HIPAA are not subject to these restrictions on when coverage may be rescinded. Some types of retroactive terminations of coverage are permissible even when fraud or intentional misrepresentations are not involved. Coverage may be retroactively terminated for failure to timely pay required premiums or contributions as required by the Plan.

Also, coverage may be retroactively terminated to the date of your divorce if you fail to notify the Plan of your divorce and you continue to cover your ex-spouse under the Plan. Coverage will be canceled prospectively for errors in coverage or if no fraud or intentional misrepresentation was made by you or your covered dependent.

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

Coverage While Not at Work

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

If You Take a Leave of Absence – FMLA

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

If You Take a Military Leave of Absence

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

Your Dental Benefits

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

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

Annual Deductible

A deductible is the amount you must pay for certain covered expenses before the Plan pays benefits. The annual deductible is $25 per person; $75 per family. The annual deductible does not apply to Class A Services. The dental deductible is separate from any other deductible that may apply under the Plan.

Coinsurance

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

Maximum Benefit

The maximum annual benefit is $1,000 per person per plan year. There is also a separate individual maximum benefit of $1,000 per lifetime for orthodontia treatment.

Covered Services

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

- Medically necessary. In order to be deemed medically necessary, a service must conform with generally accepted standards of dental practice. Sometimes there is more than one acceptable form of treatment. The Plan covers the treatment that produces good, professional dental results and costs the least. If you want a more costly treatment, you must pay the difference in cost.
- Provided by a qualified and licensed dentist, physician, denturist, or dental hygienist under supervision of a dentist or physician practicing within the scope of his or her license.
- Reasonable and customary for a covered service or supply. The maximum amount payable by the Plan will be based on the amount determined by the Plan to be the prevailing charge for a covered service or supply. The prevailing charge is based on the complexity of the service and the fee typically charged for a given service by providers with similar training or experience in a given geographical area.

The Plan pays benefits up to the maximum approved amount based on the prevailing charge for a covered service or supply. If your provider charges more than this amount, you are responsible for paying any excess charges above this limit.

A service or supply is not automatically covered simply because it is recommended or prescribed by a dentist. Should you have any questions about whether a service is covered, contact the Claims Administrator shown on your ID card.

Orthodontic Benefits

Following enrollment, there is a one year/12-month waiting period for orthodontia services. All services must be performed by a licensed dentist. Orthodontia benefits are available only to covered dependents up to age 19. A separate deductible as shown in the chart below applies to orthodontia expenses and cannot be used to satisfy any other deductible. All orthodontia expenses must be reasonable and necessary, and incurred for the diagnosis and treatment of malposed teeth. Benefits are payable only if such treatment is required to move and correct the position of maloccluded or malpositioned teeth, such as an overbite, maxillary and mandibular arches in either a protrusive or retrusive relation of at least one cusp, or a cross bite. Payments for orthodontia treatment will only be made if the participant is still covered under the Plan and is still receiving orthodontic treatment. Benefits will be paid in accordance with the approved treatment plan over a period of up to 8 calendar quarters.

Summary of Dental Benefits

Annual Maximum Benefit (per plan year)	$1,000 per person
Annual Deductible (per plan year)	$25/person $75/family
Orthodontia Maximum Benefit (per lifetime)	$1,000 One Year Waiting Period
Orthodontia Deductible (per plan year)	$25/person $75/family
Major and Prosthodontic (Class C) Services	One Year Waiting Period

Diagnostic and Preventive Care (Class A) Services	**Plan Pays**
Oral exams (limited to 2 per plan year)	100%
Bite-wing X-Rays (limited to 2 per plan year)	100%
Full mouth x-rays (limited to 1 per 3 year period)	100%
Prophylaxis (dental or periodontal) - cleaning of the teeth (limited to 2 per plan year)	100%
Topical fluoride applications (limited to 1 per plan year) (limited to dependent children under age 19)	100%

Diagnostic and Preventive Care (Class A) Services	Plan Pays
Topical application of sealants on permanent molars (limited to 1 per plan year) (limited to dependent children under age 19)	100%
Space maintainers and their fitting (limited to 1 per plan year) (limited to dependent children under age 19)	100%
Emergency palliative treatment to relieve pain	100%

Therapeutic and Restorative (Class B) Services	Plan Pays
Periapical x-rays (PAS)	80%
Any x-rays needed to diagnose a condition requiring treatment	80%
Extraction of teeth, cutting procedures in the mouth, and treatment of fractures and dislocations of the jaw (but excluding charges for removal of stitches or post-operative exams)	80%
Periodontics (treatment of the gums and support structures of the teeth)	80%
Root canals and other endodontic treatments	80%
General anesthetics and their administration in connection with oral surgery, Periodontics, fractures, and dislocations	80%
Injectable antibiotics	80%
Fillings or restorations consisting of amalgam, acrylic, silicate, or composite materials	80%
Recementing of inlays, crowns, and bridges	80%
Consultations with a specialist	80%

Major and Prosthodontic (Class C) Services	Plan Pays
Relining of full or partial dentures if done more than one year after initial installation	50%
Gold restorations, including inlays, onlays, and foil fillings. The cost of gold restorations in excess of the cost for other fillings will be included only when the teeth must be restored with gold.	50%
Repair of crowns, bridgework, and removable dentures	50%
Replacing an existing removable partial or full denture or fixed bridgework, adding teeth to an existing partial denture, or adding teeth to existing bridgework to replace newly extracted natural teeth. Applies only if existing denture or bridgework was installed at least five years prior to its replacement and cannot be made serviceable.	50%
Rebasing of removable dentures or existing dentures which have not been replaced by a new denture	50%
Full to partial dentures, fixed bridges, or adding teeth to an existing denture due to loss of natural teeth while participant is covered under the Plan, or to replace an existing prosthesis which is over five years old.	50%
Crowns and gold fillings necessary to restore the structure of teeth broken down by decay/injury (charge for a crown or gold filling is limited to the charge for a silver, porcelain or other filling material unless the tooth cannot be restored with such materials); covered only if the crown or gold filling is over five years old.	50%
Dental implant surgery	50%

Orthodontia Benefits	Plan Pays
Treatment and services necessary to move and correct the position of maloccluded or malpositioned teeth.	50%

Dental Exclusions

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

- Charges for dental care that is not medically necessary as prescribed by a physician or dentist;
- Charges for any services not shown in the Summary of Dental Benefits above;
- Charges incurred for completing claim forms or for providing reports;
- Charges for broken or missed appointments;
- Charges in excess of the maximum amount payable under the Plan (see “Maximum Allowed Amount”);
- Charges you are not legally obligated to pay;
- Charges for benefits payable under any other coverage of this Plan;
- Charges for services and supplies furnished in a U.S. Government hospital;
- Charges for services provided by a person who normally lives with the Plan participant, you or your spouse, or you or your spouse’s parent, child, brother, or sister;
- Correction of congenital conditions;
- Cosmetic services, including personalization or characterization of dentures, bleaching of teeth, facing on pontics or crowns posterior to the second bicuspid, or precision attachments;
- Crowns for teeth that are restorable by other means for the purpose of periodontal splinting;
- Crowns, fillings, or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, restoring the bite (occlusion) or that are cosmetic in nature;
- Drugs or medicines other than antibiotic injections and desensitizing medications administered by your dentist;
- Duplicate prosthetic devices or other dental applications;
- Education and training in personal oral hygiene, dental plaque control, or dietary and nutritional counseling;
- Expenses for porcelain veneered crowns or pontics in excess of acrylic veneer crowns or pontics;
- Expenses for initial placement of a complete or partial denture or fixed bridgework if it involves replacement of one or more natural teeth missing or lost prior to the effective date of coverage;
- Expenses for any dental services or supplies for treatment of teeth missing prior to the effective date of coverage (including congenitally missing teeth);
- Expenses for facings on pontics or crowns posterior to the second bicuspid;
- Expenses for barrier technique or sterilization of dental equipment and supplies;
- Occlusal analysis, occlusal adjustments, mouth guards or occlusal guards, or any similar take home item;
- Replacement of a lost, missing, or stolen prosthetic device or other dental appliance;

- Retreatment or additional treatment necessary to correct or relieve results of a previous treatment;
- Services or supplies which are covered by any employer's liability laws;
- Services or supplies which are covered by any workers' compensation or occupational disease laws;
- Services that do not meet the standards of dental practices, accepted by the American Dental Association;
- Treatment which is considered to be experimental by the dental profession;
- Treatment received because of injury, disease, or dental defect resulting from declared or undeclared war or act of war;
- Treatment received before becoming covered under the Plan or after coverage terminates;
- Veneers (bonding of coverings to the teeth);
- Expenses for class C services for the first year covered under the plan.

For More Information

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

Administrative Information

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

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

Plan Sponsor and Administrator

Cherokee County, NC is the Plan Sponsor and the Plan Administrator for this Plan. You may contact the Plan Administrator at the following address and telephone number:

Cherokee County, NC
75 Peachtree Street
Murphy, NC 28906
828-837-2735

The Plan Administrator will have control of the day-to-day administration of this Plan and will serve without additional remuneration if such individual is an employee of the County. The Plan Administrator will have the following duties and authority with respect to the Plan:

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

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

Plan Year

The Plan Year is July 1 through June 30.

Type of Plan

This Plan is called a “welfare plan”, which includes group dental plans; they help protect you against financial loss in case of sickness or injury.

Identification Numbers

The Employer Identification Number (EIN) and Plan number for the Plan is:

EIN: 56-6000285 PLAN NUMBER: 501

Plan Funding and Type of Administration

Funding and administration of the Plan is as follows.

Type of Administration	Benefits are self-funded and are administered through contracts with third-party administrators.
Funding	The County and employees both contribute to the Plan. The County will use these contributions to pay benefits to or on behalf of Plan Participants from the County’s general assets. Employee contributions toward the cost of a particular benefit will be used in their entirety prior to using County contributions to pay for the cost of such benefit.

Claims Administrators

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

The Plan Administrator has also contracted with different third-party administrators, to handle certain day-to-day administrative functions such as utilization review. While these service providers make every attempt to provide accurate information, mistakes can occur. It is important to understand that the Plan documents always control, even if their terms conflict with information given to you by a service provider.

Dental/COBRA

Claims Administrator

Crescent Health Solutions, Inc.
1200 Ridgefield Blvd.
Suite 215
Asheville, NC 28806
828-670-9145
www.crescenths.com

Agent for Service of Legal Process

If any disputes arise under the Plan, papers may be served upon:

County Manager
Cherokee County, NC
75 Peachtree Street
Murphy, NC 28906
828-837-2735

Service of legal process also can be made upon the Plan Administrator.

No Obligation to Continue Employment

The Plan does not create an obligation for the County to continue your employment or interfere with the County's right to terminate your employment, with or without cause.

Severability

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

Payment of Benefits

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

Payment of Benefits to Others

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

Expenses

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

Fraud

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

Indemnity

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

Compliance with Federal Mandates

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

Non-discrimination

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

Future of the Plan

The County expects that the Plan will continue indefinitely. However, the County has the sole right to amend, modify, suspend, or terminate all or part of the Plan at any time.

The County may also change the level of benefits provided under the Plan at any time. If a change is made, benefits for claims incurred after the date the change takes effect will be paid according to the revised Plan provisions. In other words, once a change is made, there are no rights to benefits based on earlier Plan provisions.

Claims Procedures

This section describes what you must do to file or appeal a claim for services received. There is no dental network associated with this Plan.

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

To be eligible for reimbursement under the Plan, a claim must be submitted within the time frames established by the Plan Administrator. Claims filed after that time may be reduced or denied. If you are unable to file a claim within the prescribed time frame, the Plan Administrator may elect to approve the claim after reviewing any extenuating circumstances if the claim is filed as soon as possible.

When Claims Should Be Filed

Claims should be filed with the Claims Processor within one year of the date charges for the service(s) 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:

This one year period will not apply when the person is not legally capable of submitting the claim.

The Claims Processor 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.

Time Frames for Processing a Claim

If you or your representative fail to follow the Plan's procedures for filing a claim or if you file an incomplete claim, the Plan will notify you or your representative of the failure according to the time frames shown in the following chart.

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

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

Time Frames for Processing a Claim				
Claim Process	**Urgent Care Claim**	**Concurrent Care Claim**	**Pre-Service Health Claim**	**Post-Service Health Claim**
Claims Administrator determines initial claim is improperly filed (not filed according to Plan procedures) or is not complete	Within 24 hours after receipt of improper or incomplete claim (notification may be oral unless you or your representative request otherwise)	Within 24 hours after receipt of request for extension of urgent concurrent care	Within 5 days after receipt of improper or incomplete claim (notification may be oral unless you or your representative request otherwise)	Not applicable
Claims Administrator determines that you must submit additional information required to complete claim	Within 48 hours after receipt of notice that your claim is incomplete	Not applicable	Within 45 days after receipt of notice that additional information is required	Within 45 days after receipt of notice that additional information is required
Claims Administrator reviews claim and makes determination of:		For urgent care claims, within 24 hours after receipt of the claim, provided request is submitted at least 24 hours prior to expiration of prescribed period of time or number of treatments. If not submitted within 24 hours prior to expiration of prescribed period of time or number of treatments, not later than 72 hours after receipt of claim.* For non-urgent care claims, determination will be made within time frame designated for type of claim (pre- or post-service) and prior to expiration of prescribed period of time or number of treatments.*		
complete/proper claim	Within 48 hours after the earlier of: receipt of requested information, or at end of period allowed for you to provide information		Within 15 days after the earlier of: receipt of requested information, or at end of 45-day period allowed for you to provide information	Within 30 days after the earlier of: receipt of requested information, or at end of 45-day period allowed for you to provide information
initial claim	Within 24 hours of receipt of initial claim		Within 15 days of date initial claim is received	Within 30 days of date initial claim is received
Extension period,** if required due to special circumstances beyond control of Claims Administrator	Not applicable	Not applicable	Additional 15 days if Plan requires more information from you and provides an extension notice during initial 15-day period	Additional 15 days if Plan requires more information from you and provides an extension notice during initial 30-day period

* A request for extension of treatment will be deemed to be an initial claim. A reduction or termination of approved, ongoing treatment will be deemed to be an adverse claim decision. If the Claims Administrator makes an adverse decision, you will be notified of the reduction/termination within a time frame that allows you to submit an appeal and have a determination on the appeal prior to the expiration of the prescribed period of time or number of treatments.

** Whenever an extension is required, the Plan must notify you before the current determination period expires. The notice must state the circumstances requiring the extension and the date a determination is expected to be made.

How to Appeal a Claim

To appeal a denied claim or to review administrative documents pertinent to the claim, you or your representative must send a written request to the Plan. You may also appeal the Plan's decision to rescind your coverage due to fraud or intentional misrepresentation of material fact. The time frames for appealing a claim are shown in the following chart.

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

Time Frames for Appealing Denied Claims

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

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

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

Exhaustion Required

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

Coordination of Benefits

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

Non-Duplication of Benefits / Coordination of Benefits

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

Your dental benefits are coordinated with benefits from:

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

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

How Non-Duplication Works

When an expense is covered by two plans, the Plan will calculate normal benefits, then subtract payments made by other carriers, with combined payments totaling up to 100 percent of allowable charges. Any remaining benefit above 100 percent of charges that the Plan could have paid, but did not, will be placed in a credit reserve and be applied to future unpaid claims.

Determining Primary and Secondary Plans

Primary and secondary plans are determined as follows.

A plan that does not contain a coordination of benefits provision is primary.

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

becomes secondary and will pay before the plan of the parent without custody (the third plan).

- If the remarried parent with custody has no health care coverage, the stepparent's plan is primary and the plan of the parent without custody is secondary.
- Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses and that parent has enrolled the child in his or her plan, that parent's plan is primary.
- When none of the previous rules applies, the plan that has covered the patient for the longer period is primary.

For Maximum Benefit

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

Right to Reimbursement

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

Third Parties

The following persons and entities are considered third parties:

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

When This Provision Applies To You

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

As a condition of receiving benefits under this Plan, you agree that acceptance of benefits for you and/or your dependents is constructive notice of this provision in its entirety and agree to reimburse the Plan 100 percent of any benefits provided or to be provided without reduction for attorney's fees, costs, comparative negligence, limits of collectability or responsibility, or

otherwise. You further agree that the Plan shall have an equitable lien on any funds received by you or your dependents, and/or you or your attorney, if any, from any source for any purpose and shall be held in trust until such time as the obligation under this provision is fully satisfied. If you or your dependent retains an attorney, then you and your dependents agree to only retain one who will not assert the Common Fund or Made-Whole Doctrines. Reimbursement shall be made immediately upon collection of any sum(s) recovered regardless of its legal, financial or other sufficiency. If the injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision regardless of state law and/or whether the minor's representative has access or control of any recovery funds.

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

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

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

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

Your HIPAA/COBRA Rights

Health Insurance Portability and Accountability Act (HIPAA)

Title II of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations at 45 CFR Parts 160 through 164 (HIPAA) contain provisions governing the use and disclosure of Protected Health Information (PHI) by group health plans, and provide privacy rights to participants in those plans. These rules are called the HIPAA Privacy Rules.

You will receive a “Notice of Privacy Practices” from the Administrator(s) and/or Insurer(s) that contains information about how your individually identifiable health information is protected under the HIPAA Privacy Rules and who you should contact with questions or concerns.

The HIPAA Privacy Rules apply to group health plans. These plans are commonly referred to as “HIPAA Plans” and are administered to comply with the applicable provisions of HIPAA. PHI is individually identifiable information created or received by HIPAA Plans that relates to an individual’s physical or mental health or condition, the provision of health care to an individual, or payment for the provision of health care to an individual. Typically, the information identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper or oral. When PHI is in electronic form it is called “ePHI.”

The HIPAA Plans may disclose PHI to the Plan Sponsor only as permitted under the terms of the Plan, or as otherwise required or permitted by HIPAA. The Plan Sponsor agrees to use and disclose PHI only as permitted or required by the HIPAA Privacy Rules and the terms of the Plan.

The HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose enrollment and disenrollment information to the Plan Sponsor. Also, the HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the information for the purposes of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending or terminating the Plan. “Summary Health Information” means information that summarizes the claims history, claims expenses or types of claims experienced by individuals covered under the HIPAA Plans and has almost all individually identifying information removed. The HIPAA Plans may also disclose PHI to the Plan Sponsor pursuant to a signed authorization that meets the requirements of the HIPAA Privacy Rules.

In addition, the HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose PHI to the Plan Sponsor for plan administration purposes. Plan administration purposes means administration functions performed by the Plan Sponsor on behalf of the HIPAA Plans, such as claims processing, coordination of benefits, quality assurance, auditing and monitoring. Plan administration purposes do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor or any employment-related actions or decisions.

The Plan Sponsor agrees that with respect to any PHI (other than enrollment/disenrollment information, Summary Health Information and information disclosed pursuant to a valid HIPAA authorization) disclosed to it by the HIPAA Plans (or an Insurer with respect to the HIPAA Plans), the Plan Sponsor will:

- Not use or further disclose the information other than as permitted or required by the Plan or as required by law;
- Ensure that any agents, including subcontractors, to whom it provides PHI received from the HIPAA Plans agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;
- 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 HIPAA Plans any use or disclosure of PHI of which it becomes aware that is inconsistent with the permissible uses or disclosures;
- Make PHI available in accordance with the individual rights of access under the HIPAA Privacy Rules;
- Make an individual's PHI available for amendment, and incorporate any amendments, as required by the HIPAA Privacy Rules;
- Make available the information required to provide an accounting of disclosures to individuals, as required by the HIPAA Privacy Rules;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the HIPAA Plans available to the Secretary of the Department of Health and Human Services for purposes of determining compliance with HIPAA's requirements;
- If feasible, return or destroy all PHI received from the HIPAA Plans that the Plan Sponsor still maintains in any form and retain no copies of this information when no longer needed for the purpose for which disclosure was made, except that, if this return or destruction is not feasible, limit further uses or disclosures to those purposes that make the return or destruction of the information infeasible; and
- Ensure adequate separation between the HIPAA Plans and the Plan Sponsor is established.

In addition, the Plan Sponsor will reasonably and appropriately safeguard ePHI (other than enrollment/disenrollment information, Summary Health Information and information disclosed pursuant to a valid HIPAA authorization) that is created, received, maintained or transmitted to or by the Plan Sponsor on behalf of the HIPAA Plans. The Plan Sponsor will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains or transmits on behalf of the HIPAA Plans;
- Ensure that adequate separation between the HIPAA Plans and the Plan Sponsor is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the information; and
- Report to the HIPAA Plans any security incident of which it becomes aware.

Continuing Dental Care Coverage through COBRA

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

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

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

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

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

For more information about the Marketplace, visit www.HealthCare.gov.

COBRA Qualifying Events and Length of Coverage

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

18-Month Continuation

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

- employment ends for any reason other than gross misconduct; or
- hours of employment are reduced.

18-Month Continuation Plus 11-Month Extension

If you or your eligible dependent is disabled at the time your employment ends or your hours are reduced, the disabled person may receive an extra 11 months of coverage in addition to

the 18-month continuation period (for a total of 29 months of coverage). If the individual entitled to the disability extension has non-disabled family members who have COBRA coverage due to the same qualifying event, those non-disabled family members will also be entitled to the 11-month extension, including any child born or placed for adoption within the first 60 days of COBRA coverage.

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

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

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

36-Month Continuation

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

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

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

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

COBRA Notifications

If you or your covered dependents lose coverage under the Plan because your employment status changes, you become entitled to Medicare, or you die, the Plan Administrator (or its designated COBRA administrator) will automatically provide you or your dependents with additional information about COBRA continuation coverage, including what actions you must take by specific deadlines.

If your covered dependent loses coverage as a result of your divorce, legal separation or a dependent child's loss of eligibility under the Plan, you or your dependent must notify the County within 60 days of the qualifying event. The Plan Administrator (or its designated

COBRA administrator) will automatically send you or your dependent, as applicable, COBRA enrollment information. If you or your dependent fails to provide notification of the event within 60 days, you or your dependent forfeits all continuation of coverage rights under COBRA. To continue COBRA coverage, you and/or your eligible dependents must elect and pay the required cost for COBRA coverage.

Cost of COBRA Coverage

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

COBRA Continuation Coverage Payments

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

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

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

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

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

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

How Benefit Extensions Impact COBRA

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

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

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

When COBRA Coverage Ends

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

- The premium for COBRA coverage is not paid on a timely basis (monthly payments must be postmarked within the 30-day grace period, your initial payment must be postmarked within 45 days of your initial election).
- The maximum period of COBRA coverage, as it applies to the qualifying event, expires.
- The individual becomes covered under any other group dental plan.
- The County terminates its group health plan coverage for all employees.
- Social Security determines that an individual is no longer disabled during the 11-month extension period.

Definitions

Accident

An unexpected or reasonably unforeseen occurrence or event that is definite as to time and place.

Actively at Work

A participant is considered actively at work if he or she:

- is presently at work on a scheduled workday performing the regular duties of his or her job for the hours he or she is normally scheduled to work; or
- was present at work on the last scheduled working day before:
    - a scheduled vacation;
    - an absence due to a paid holiday, paid jury or witness day, or a paid bereavement day;
    - a scheduled day off within the participant's working schedule; or
    - an absence excused by the County.

COBRA

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

Coinsurance

The percentage of the cost of covered expenses a participant must pay after meeting any applicable deductible.

Complete Claim (Proper Claim)

A previously incomplete claim for which a participant has submitted the missing or additional information required for the Plan to make a determination.

Concurrent Care Claim

A claim for a benefit that involves an ongoing course of treatment.

Co-payment

The fixed dollar amount of covered expenses a participant must pay before Plan pays.

Deductible

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

Diagnostic Service

A test or procedure performed for specified symptoms to detect or to monitor a disease or illness and ordered by a physician or professional provider.

Doctor/Physician

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

Eligible Provider

Any practitioner or facility offering covered services and acting within the scope of the appropriate license; examples include a licensed doctor, osteopath, podiatrist, chiropractor, hospital, or laboratory.

Employee

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

Experimental or Investigational Services

Medical, surgical, diagnostic, psychiatric, substance abuse, or other dental care services, technologies, supplies, treatments, procedures, drug therapies, or devices that, at the time the Plan makes a determination regarding coverage in a particular case, are determined to be:

- not approved by the U.S. Food & Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
- subject to review and approval by any institutional review board for the proposed use; or
- not demonstrated through authoritative medical or scientific literature published in the U.S. to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Family and Medical Leave Act

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

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

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

HIPAA

Health Insurance Portability and Accountability Act of 1996, as amended.

HITECH

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

Hospital

A legally licensed facility that:

- is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Hospitals; or
- provides a broad range of 24-hour-a-day medical and surgical services by or under the direction of a staff of doctors and is engaged primarily in providing either:
    - general inpatient medical care and treatment through medical, diagnostic, and major surgical facilities on its premises or under its control; or
    - specialized inpatient medical care and treatment through medical and diagnostic facilities (including X-ray and laboratory) on its premises, under its control, or through a written agreement with a hospital that itself qualifies under the above description, or with a specialized provider of these facilities.

The term hospital does not include a facility that primarily is a place for rest, a place for the aged, or a nursing home.

Illness (or Disease)

A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory finding peculiar to it and that sets the condition apart as an abnormal entity differing from other normal or pathological body states.

Improper Claim

A claim that is not filed according to Plan procedures. A participant or his or her representative will be notified if a claim is determined to be filed improperly. The notice will contain the steps and the time frame that must be followed to resubmit the claim for a determination.

Incomplete Claim

A claim that does not contain sufficient information for a determination to be made. A participant or his or her representative will be notified if a claim is determined to be incomplete. The notice will contain a description of the additional information required and the time frame that must be followed to resubmit the claim for a determination.

Injury

An accidental bodily injury that is the sole and direct result of an accident or a reasonably unforeseeable consequence of a voluntary act by the person. :

Leased Employee

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

Medical Condition

A condition for which the individual has sought and received medical treatment.

Medically Necessary

To be medically necessary, all care must be:

- in accordance with standards of good medical practice;
- consistent in type, frequency, and duration of treatment with scientifically based guidelines, as accepted by the Plan;

- required for reasons other than the convenience of the health care provider or the comfort or convenience of the patient;
- provided in a cost-efficient manner and type of setting appropriate for the delivery of that service/supply;
- consistent with the eligible diagnosis of the condition;
- not experimental or investigational, as determined by the Plan; and
- demonstrated through authoritative medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

The fact that a doctor performs or prescribes a procedure or treatment or that it may be the only treatment for a particular condition does not mean that it is medically necessary as defined here.

The Plan reserves the right to conduct a utilization review to determine whether services are medically necessary for the proper treatment of the participant and may also require the participant to be independently examined while a claim is pending.

NMHPA

The Newborns' and Mother's Health Protection Act of 1996, as amended. Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Participant

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

Post-Service Dental Claim

A claim for a benefit under the Plan that is not a pre-service claim.

PPACA

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

Pre-Service Dental Claim

A claim for a benefit that, under the terms of the Plan, requires a participant to receive, in whole or in part, prior approval from the Plan as a condition to receive the benefit.

Prudent Layperson

An individual who possesses an average knowledge of health and medicine and, therefore, is able to determine that the absence of immediate medical attention may result in a serious medical condition for an ill or injured person.

Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN)

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

Skilled Nursing Facility

A facility that qualifies under the Health Insurance of the Aged and Disabled provisions of the United States Social Security Act (Medicare), as amended; and is approved by the Plan.

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

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

Adoption of the Plan

The Health and Welfare Benefit Plan, effective 07/01/2005, as amended and restated herein, is hereby adopted as of 07/01/2021. This document constitutes the basis for administration of the Plan.

IN WITNESS WHEREOF, the parties have caused this document to be executed on this 21st day of June, 2021.

BY: _____

TITLE: County Manager