

---

**PLAN DOCUMENT AND  
SUMMARY PLAN DESCRIPTION  
FOR**

**WASHTENAW COUNTY ROAD COMMISSION DENTAL AND VISION PLAN**

---

## TABLE OF CONTENTS

INTRODUCTION.....	1
ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS .....	2
OPEN ENROLLMENT.....	8
SCHEDULE OF BENEFITS .....	9
DEFINED TERMS .....	12
VISION CARE BENEFITS.....	15
DENTAL BENEFITS.....	16
HOW TO SUBMIT A CLAIM.....	20
COORDINATION OF BENEFITS.....	24
THIRD PARTY RECOVERY PROVISION .....	27
CONTINUATION COVERAGE RIGHTS UNDER COBRA .....	29
RESPONSIBILITIES FOR PLAN ADMINISTRATION .....	35
GENERAL PLAN INFORMATION .....	40

## INTRODUCTION

This document is a description of Washtenaw County Road Commission Dental and Vision Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain other expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

**Eligibility, Funding, Effective Date and Termination.** Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

**Schedule of Benefits.** Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

**Benefit Descriptions.** Explains when the benefit applies and the types of charges covered.

**Defined Terms.** Defines those Plan terms that have a specific meaning.

**Claim Provisions.** Explains the rules for filing claims and the claim appeal process.

**Coordination of Benefits.** Shows the Plan payment order when a person is covered under more than one plan.

**Third Party Recovery Provision.** Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

**Continuation Coverage Rights Under COBRA.** Explains when a person's coverage under the Plan ceases and the continuation options which are available.

**ERISA Information.** Explains the Plan's structure and the Participants' rights under the Plan.

## **ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS**

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

### **ELIGIBILITY**

**Eligible Classes of Employees.** Eligible classes are all full time regular employees of the Washtenaw County Road Commission who are either members of the Teamsters or AFSCME bargaining units, or non-union employees. Eligibility is in accordance with the regular schedule for awarding these benefits according to Union contracts or policy.

**Eligibility Requirements for Employee Coverage.** A person is eligible for Employee coverage from the first day that he or she:

- (1) is a Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if he or she normally works at least 30 hours per week and is on the regular payroll of the Employer for that work. Retirees as defined by the Employer. **(Retirees are eligible for dental benefits only)**
- (2) is in a class eligible for coverage.
- (3) completes the employment waiting period as an Employee. Coverage under the Plan will become effective on the day following completion of the Waiting Period.

### **Waiting Period**

A "Waiting Period" is the time between the first day of employment and the first day of coverage under the Plan. The Waiting Period is counted in the Pre-Existing Conditions exclusion time.

**Eligible Classes of Dependents.** A Dependent is any one of the following persons:

- (1) A covered Employee's Spouse and unmarried children from birth to the limiting age of 19 years. The Dependent children must be primarily dependent upon the covered Employee for support and maintenance. However, a Dependent child will continue to be covered after age 19, provided the child is a full-time student at an accredited school, primarily dependent upon the covered Employee for support and maintenance, is unmarried and under the limiting age of 23. When the child reaches either limiting age as a dependent at age 19 or full-time student up to age 23, coverage will end on the last day of the year the child reaches that limiting age.

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator may require documentation proving a legal marital relationship.

The term "children" shall include natural children, adopted children, Foster Children or children placed with a covered Employee in anticipation of adoption. Step-children who reside in the Employee's household may also be included as long as a natural parent remains married to the Employee and also resides in the Employee's household.

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

In all cases, to qualify as an eligible Dependent under the Plan, the child must be dependent upon the covered Employee for over one-half of his support during the Plan Year. A special rule applies in the case of a child of divorced parents, legally separated parents or parents who lived apart at all times of the year or during the last six months of the calendar year. The child will be considered dependent upon the Employee for over one-half of his support if the child is in the custody of the Employee and/or the other parent for more than one-half of the year and the child is dependent upon one and/or both parents for more than one-half of his support for the year. The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

- (2) A covered Dependent child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for all amounts applied to maximums.

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

**Eligibility Requirements for Dependent Coverage.** A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

## **FUNDING**

**Cost of the Plan.** Washtenaw County Road Commission shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be filled out, signed and returned with the enrollment application.

The level of any employee contribution is set by the current union contracts. This may change depending on modification to future contracts.

## **ENROLLMENT**

**Enrollment Requirements.** An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. If the covered Employee already has Dependent coverage, a newborn child will be automatically enrolled for 31 days from birth; otherwise, separate enrollment for a newborn child is required.

## **Enrollment Requirements for Newborn Children.**

### **TIMELY ENROLLMENT**

**Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage.

If two Employees (the mother and father of the child(ren)) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee as long as coverage has been continuous.

### **SPECIAL ENROLLMENT RIGHTS**

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or his dependents (including their spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 31 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days after the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator, Washtenaw County Road Commission, 555 North Zeeb Road, Ann Arbor, Michigan, 48103, 734-761-1500.

### **SPECIAL ENROLLMENT PERIODS**

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

- (1) Individuals losing other coverage creating a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage is due to any of the following conditions:
  - (a)** The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
  - (b)** If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
  - (c)** The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.
  - (d)** The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

- (e) For purposes of these rules, a loss of eligibility occurs if:
  - (i) The Employee or Dependent has a loss of eligibility on the earliest date a claim is denied that would meet or exceed a lifetime limit on all benefits.
  - (ii) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e.: part-time employees).
  - (iii) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.
  - (iv) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).
  - (v) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

**(2) Dependent beneficiaries. If:**

- (a) The Employee is a participant under this Plan (or is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
- (b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 31-day period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

- (a) in the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received;
- (b) in the case of a Dependent's birth, as of the date of birth; or
- (c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

## EFFECTIVE DATE

**Effective Date of Employee Coverage.** An Employee will be covered under this Plan as of the first day that the Employee satisfies all of the following:

- (1) The Eligibility Requirement.
- (2) The Active Employee Requirement.
- (3) The Enrollment Requirements of the Plan.

### **Active Employee Requirement.**

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

**Effective Date of Dependent Coverage.** A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

## TERMINATION OF COVERAGE

**When Employee Coverage Terminates.** Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

- (1) The date the Plan is terminated.
- (2) The day the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the section entitled Continuation Coverage Rights under COBRA.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.
- (3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- (4) If an Employee commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage.

**Continuation During Family and Medical Leave.** This Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

**Rehiring a Terminated Employee.** A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

**Employees on Military Leave.** Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

- (1) The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:
  - (a) The 24 month period beginning on the date on which the person's absence begins; or
  - (b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.
- (2) A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
- (3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator Washtenaw County Road Commission, 555 North Zeeb Road, Ann Arbor, Michigan, 48103, 734-761-1500. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

**When Dependent Coverage Terminates.** A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

- (1) The date the Plan or Dependent coverage under the Plan is terminated.
- (2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA.)
- (3) The date a covered Spouse loses coverage due to loss of dependency status. (See the section entitled Continuation Coverage Rights under COBRA.)
- (4) When a Dependent child reaches limiting age or no longer meets the requirements of a full time student, coverage will end. However when a student attains the limiting age, coverage will end at the end of the calendar year in which the student reaches the limiting age.
- (5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- (6) If a Dependent commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage.

## **OPEN ENROLLMENT**

### **OPEN ENROLLMENT**

Open enrollment occurs during a designated time frame as determined by the Plan Administrator.

Benefit choices made during the open enrollment period will become effective January 1 and remain in effect until the next January 1 unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverages.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

**SCHEDULE OF BENEFITS**

**Verification of Eligibility (616) 285-2480**

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

**NON-TEAMSTERS SCHEDULE OF VISION BENEFITS (Retirees are not eligible for vision coverage)**

Eye exam, per person, in a 12 month period..... \$60.

Frame-type lenses, per pair, in a 12 month period:

Single vision..... \$72.

Bi-focal ..... \$96.

Tri-focal ..... \$120.

Lenticular ..... \$144.

Frames, per pair, in a 24 month period ..... \$60.

Contact Lenses, per pair, in a 12 month period

If prescribed in one of these cases:..... \$180.00

- (1) A person's vision cannot be corrected to 20/70 in the better eye except by use of contact lenses.
- (2) A person needs contact lenses after cataract surgery.
- (3) A person is being treated for a condition such as Keratinous or Anisometropia and contact lenses are routinely used as a part of the treatment.

If prescribed for any other reason..... if contact lenses are chosen in lieu of glasses this Plan, will pay \$20.00 for examination fees and expenses up to \$20.00 for materials during any 12 consecutive months.

Maximum Benefit Period – one exam and/or lenses in any consecutive 12 month period.  
One frame in any consecutive 24 month period.

**VISION CARE BENEFITS FOR TEAMSTERS ONLY**

Eye exam, per person, in a 12 month period..... \$60.

Frame-type lenses, per pair, in a 12 month period:

Single vision..... \$72.

Bi-focal ..... \$96.

Tri-focal ..... \$120.

Lenticular ..... \$144.

Frames, per pair, in a 24 month period ..... \$60.

Contact Lenses, per pair, in a 12 month period: (\$60. Exam & \$72. Contact lens in lieu of glasses)

If prescribed in one of these cases:..... \$180.00

- (1) A person's vision cannot be corrected to 20/70 in the better eye except by use of contact lenses.
- (2) A person needs contact lenses after cataract surgery.
- (3) A person is being treated for a condition such as Keratinous or Anisometropia and contact lenses are routinely used as a part of the treatment.

If contact lenses are purchased in lieu of glasses this Plan will pay \$60.00 for an exam and \$72.00 for contacts.

Maximum Benefit Period – one exam and/or lenses in any consecutive 12 month period.  
 One frame in any consecutive 24 month period.

**DENTAL BENEFITS**

**Please read the sections Alternate Treatment and Predetermination of Benefits in the Dental Plan. You will need to follow these sections or reimbursement from the Plan may be reduced.**

Calendar Year deductible, per person.....	\$25.
per Family Unit.....	\$75.

The deductible applies to these Classes of Service:

- Class B Services - Basic
- Class C Services - Major

**Dental Percentage Payable**

Class A Services - Preventive.....	100%
Class B Services - Basic.....	100%
Class C Services - Major.....	50%
Class D Services - Orthodontia.....	50%

**Maximum Benefit Amount**

For Class A, B, and C Services: Per person per Calendar Year.....	\$1,000.00
For Class D - Orthodontia: (orthodontic services to age 19)  Lifetime maximum per person .....	\$1,000.

**Retirees Maximum Payment - \$500.00**

## DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

**Active Employee** is an Employee who is on the 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.

**Calendar Year** means January 1st through December 31st of the same year.

**COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

**Cosmetic Dentistry** means dentally unnecessary procedures.

**Covered Charge(s)** means those Medically Necessary services or supplies that are covered under this Plan.

**Covered Person** is an Employee or Dependent who is covered under this Plan.

**Dentist** is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

**Employee** means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

**Employer** is Washtenaw County Road Commission.

**Enrollment Date** is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

**ERISA** is the Employee Retirement Income Security Act of 1974, as amended.

**Experimental and/or Investigational** means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the dental community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

- (1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- (2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- (3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- (4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

**Family Unit** is the covered Employee and the family members who are covered as Dependents under the Plan.

**Foster Child** means an unmarried 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; the child lives in the home of the covered Employee; and the covered Employee may legally claim the child as a federal income tax deduction.

A covered Foster Child is not 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 parent(s) may exercise or share parental responsibility and control.

**Injury** means an accidental physical Injury to the body caused by unexpected external means.

**Lifetime** is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

**Medically or Dentally Necessary** care and treatment is recommended or approved by a Physician or Dentist; is consistent with the patient's condition or accepted standards of good dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of dental services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

**No-Fault Auto Insurance** is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

**Physician** means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Optometrist (O.D.), Doctor of Podiatry (D.P.M.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Doctor of Dental Surgery (D.D.S.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

**Plan** means Washtenaw County Road Commission Dental and Vision Plan, which is a benefits plan for certain Employees of Washtenaw County Road Commission and is described in this document.

**Plan Participant** is any Employee or Dependent who is covered under this Plan.

**Plan Year** is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

**Total Disability (Totally Disabled)** means: 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 sex in good health.

**Usual and Reasonable Charge** is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

The Plan will reimburse the actual charge billed if it is less than the Usual and Reasonable Charge.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

## VISION CARE BENEFITS

Vision care benefits apply when vision care charges are incurred by a Covered Person for services that are recommended and approved by a Physician or Optometrist.

### BENEFIT PAYMENT

Benefit payment for a Covered Person will be made as described in the Schedule of Benefits.

### VISION CARE CHARGES

Vision care charges are the Usual and Reasonable Charges for the vision care services and supplies shown in the Schedule of Benefits. Benefits for these charges are payable up to the maximum benefit amounts shown in the Schedule of Benefits for each vision care service or supply.

### LIMITS

No benefits will be payable for the following:

- (1) **Before covered.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan.
- (2) **Contact lenses.** Charges for contact lenses unless prescribed in one of the following cases:
  - (a) When a Covered Person's vision cannot be corrected to 20/70 in the better eye except by the use of contact lenses.
  - (b) A Covered Person needs contact lenses after cataract surgery.
  - (c) A Covered Person is being treated for a condition such as Keratoconus or Anisometropia and contact lenses are routinely used as part of the treatment.
- (3) **Excluded.** Charges excluded or limited by the Plan design as stated in this document.
- (4) **Health plan.** Any charges that are covered under a health plan that reimburses a greater amount than this Plan.
- (5) **No prescription.** Charges for lenses ordered without a prescription.
- (6) **Orthoptics.** Charges for orthoptics (eye muscle exercises).
- (7) **Sunglasses.** Charges for safety goggles or sunglasses, including prescription type.
- (8) **Training.** Charges for vision training or subnormal vision aids.

## DENTAL BENEFITS

This benefit applies when covered dental charges are incurred by a person while covered under this Plan.

### DEDUCTIBLE

**Deductible Amount.** This is an amount of dental charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year, a Covered Person must meet the deductible shown in the Schedule of Benefits.

**Family Unit Limit.** When the dollar amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

### BENEFIT PAYMENT

Each Calendar Year benefits will be paid to a Covered Person for the dental charges in excess of the deductible amount if applicable. Payment will be made at the rate shown under Dental Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

### MAXIMUM BENEFIT AMOUNT

The Maximum dental benefit amount is shown in the Schedule of Benefits.

### DENTAL CHARGES

Dental charges are the Usual and Reasonable Charges made by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

## COVERED DENTAL SERVICES

### Class A Services: 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, but not more than twice in a Calendar Year.
- (2) Routine prophylaxis (cleaning and scaling of teeth) by a Dentist or dental hygienist, but not more than twice per Calendar Year.
- (3) Fluoride treatment by a Dentist or dental hygienist, but not more than once in a Calendar Year.
- (4) Dental x-rays, but not more than
  - (a) one full-mouth series of x-rays in any period of three consecutive Calendar Years; and
  - (b) four supplemental bite-wing x-rays in a calendar year.
- (5) Space maintainers.
- (6) Dental sealants applied to the first and second permanent molars, but
  - (a) only for dependents who are age 15 or younger; and
  - (b) only when the teeth have not been treated with sealants for at least four years.

**Class B Services:  
Basic Dental Procedures**

- (1) Extractions
- (2) Oral Surgery
- (3) Fillings necessary to restore the structure of the teeth broken down by decay or injury. Composite fillings that are for cosmetic purposes will be paid at the reasonable and customary charge of an amalgam filling, gold fillings are excluded.
- (4) Periodontic procedures (procedures for treatment of the area around the tooth)
- (5) Endodontic procedures (procedures, such as root canal work, used for the treatment of the dental pulp.
- (6) Emergency treatment for the relief of dental pain. The Plan will pay when no other benefit, other than the dental x-rays, is payable under the policy.
- (7) General anesthesia given in connection with Covered Services.

**Class C Services:  
Major Dental Procedures**

- (1) The first placement of full or partial removable dentures, temporary dentures or fixed bridgework. This will include adjustments during the six-month period following placement. The placement must be needed as a result of the extraction of one or more natural teeth. The extraction must take place after the Employee or Dependent is covered under this provision. The denture or bridgework must include the replacement of the teeth which were extracted. The Plan will not pay for replacement of third molars (wisdom teeth)
- (2) The replacement or alteration of full or partial dentures, or fixed bridgework which is necessary because of oral surgery. This surgery must be performed while the employee or dependent is covered. The replacement or alteration must be completed within 12 months from the day of surgery.
  - (a) resulting from an accident.
  - (b) for the repositioning of muscle attachments
  - (c) for the removal of a tumor, cyst or redundant tissue.
- (3) The replacement of a full denture which is necessary because of
  - (a) Structural change within the mouth and when it has been more than five years since the prior placement.
  - (b) the first placement of an opposing full denture when the placement takes place after the employee or dependent has been covered under this provision for two years or more, or
  - (c) the prior placement of an immediate or temporary denture when the replacement occurs within 12 months of the placement of the immediate temporary denture.
- (4) Addition of teeth to, or replacement of, an existing partial or full removable denture or fixed bridgework when:

- (a) the replacement or addition is needed to replace one or more additional natural teeth which are extracted while the Employee or Dependent is covered under this provision, or
  - (b) the existing denture or bridgework was put in at least five years prior to its replacement.
- (5) Inlays, gold fillings and the first placement of crowns, including precision attachments for dentures.
  - (6) The replacement of a crown restoration when the original crown was put in more than five years prior to the replacement.
  - (7) Repair or recementing of crowns, inlays, bridgework or dentures. The Plan will include the rebasing or relining of dentures.
- .
- (8) Treatment of craniomandibular/temporomandibular (TMJ) disorders as approved by the American Academy of Craniomandibular Disorders, to include:
    - (a) diagnosis and baseline records.
    - (b) behavior modification modalities
    - (c) repair and regeneration, and
    - (d) orthopedic stabilization

**Class D Services:  
Orthodontic Treatment and Appliances**

Orthodontic care, treatment, services and supplies. The plan will not pay for orthodontia performed exclusively on primary teeth.

**CONDITIONS**

- (1) Except as otherwise specifically provided, the service must be performed by a Dentist and includes any required supplies..
- (2) Before the Plan pays any benefits, we may ask for:
  - (a) Supporting proof of loss.
  - (b) Clinical reports
  - (c) Charts, and
  - (d) X-rays
- (3) When there are two or more methods of treating a condition, expense for a covered dental service will be based upon the charges for the least expensive course of treatment.
  - (a) Which the dental profession recognizes to be adequate in accord with widely accepted standards of dental practice, and
  - (b) Which the Plan determines to be appropriate in view of the covered person's total current oral condition.
- (4) Benefits for any covered person becoming covered in accord with the late Enrollment or Reinstatement provisions will be limited to \$100. until the first of the month which coincides with or next follows the 12 months after the effective date of coverage.

## PREDETERMINATION OF BENEFITS

Predeterminations are not required but if desired to identify amounts eligible under the plan the following procedures should be followed:

The Dentist must itemize all recommended services and costs.

The Dentist should send the form to the Claims Processor at this address:

Professional Benefits Services  
2959 Luceren SE, Suite 205  
Grand Rapids, Michigan 49546  
Phone (616) 285-2480 Fax (616) 285-9965

The Claims Processor will notify the Dentist of the benefits payable under the Plan. The Covered Person and the Dentist can then decide on the course of treatment, knowing in advance how much the Plan will pay.

## EXCLUSIONS

A charge for the following is not covered:

- (1) any treatment, service or supply unless it is shown under Covered Services.
- (2) treatment of the teeth or gums for cosmetic purposes, including realignment of teeth.
- (3) expense incurred after the coverage ends, however, the Plan will pay for prosthetics (an artificial replacement of one or more natural teeth). Including bridges and crowns, which were fitted and ordered prior to the date coverage ends. The Employee or Dependent must receive the prosthetic device within 30 days after the coverage ends.
- (4) prosthetics, including bridges and crowns, started or under way prior to the date the Employee or Dependent became covered under this provision.
- (5) rebasing or relining of a denture less than six months after the first placement, and not more than one rebasing or relining in any two-year period.
- (6) replacement of lost or stolen prosthetics.
- (7) replacement of prosthetics less than five years after a previous placement, except as provided in **(2),(3)** or **(4)(a)** of Class C Services.
- (8) a new denture or bridgework if the existing denture or bridgework can be made serviceable.
- (9) charges the Employee or Dependent is not required to pay, including charges for services furnished by any hospital or organization which normally makes no charge if the patient has no hospital, surgical or dental coverage.
- (10) orthodontic care, treatment, services and supplied, except as provided under the Covered Services.
- (11) local anesthesia and analgesia and their administration.
- (12) procedures, restorations and appliances to change vertical dimension or to restore occlusion (proper contact between opposing teeth)
- (13) any expense paid in whole or in part by any other provision of the Group Health Insurance Plan provided: by the Policyholder.
- (14) Sealants (except as provided under part **(5)** of Class A Services) and
- (15) Anything excluded under the General Exclusions and Limitations.

## 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.**

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

- (1) Obtain a Claim form from the Personnel Office, Human Resources Office or the Plan Administrator.
- (2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.
- (3) Have the Physician or 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 Processor at this address:

Professional Benefits Services  
2959 Luceren SE, Suite 205  
Grand Rapids, Michigan 49546  
616-285-2480 or 1-800-732-3412

## WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Processor within 90 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 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. 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
---------------------------------------------------	----------

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
------------------------------------------------	----------

Response by claimant, orally or in writing	48 hours
--------------------------------------------	----------

Benefit determination, orally or in writing	48 hours
---------------------------------------------	----------

Ongoing courses of treatment, notification of:

Reduction or termination before the end of treatment	72 hours
------------------------------------------------------	----------

Determination as to extending course of treatment	24 hours
---------------------------------------------------	----------

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	90 days
Extension due to matters beyond the control of the Plan	15 days
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	60 days

### **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."

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.

No fees or costs will be imposed on the claimant as part of the voluntary level of appeal, and the claimant will be told this.

## COORDINATION OF BENEFITS

**Coordination of the benefit plans.** 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 due up to 100% of the total Allowable Charges.

**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) Blue Cross and Blue Shield group plans.
- (3) Group practice and other group prepayment plans.
- (4) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.
- (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 Usual and Reasonable Charge and at least part of it must be covered under this Plan.

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 parent 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.
- (4) The Plan will pay primary to Tricare to the extent required by federal law.

**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.

**Exception to Medicaid.** In accordance with ERISA, the Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.

## THIRD PARTY RECOVERY PROVISION

### RIGHT OF SUBROGATION AND REFUND

**When this provision applies.** The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The payment for benefits received by a Covered Person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Covered Person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Covered Person, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Covered Person to the payments of those benefits.

The Covered Person:

- (1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and
- (2) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

**Amount subject to Subrogation or Refund.** The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any responsible third party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

**Conditions Precedent to Coverage.** The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all

Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

**Defined terms:** "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

**Recovery from another plan under which the Covered Person is covered.** This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

**Rights of Plan Administrator.** The Plan Administrator has a right to request reports on and approve of all settlements.

## CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under Washtenaw County Road Commission Dental and Vision Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is Washtenaw County Road Commission, 555 North Zeeb Road, Ann Arbor, Michigan, 48103, 734-761-1500. The Plan Administrator is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

**What is COBRA continuation coverage?** COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

**Who can become a Qualified Beneficiary?** In general, a Qualified Beneficiary can be:

- (1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes not only common-law employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

**What is a Qualifying Event?** A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- (1) The death of a covered Employee.
- (2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- (3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.
- (4) A covered Employee's enrollment in any part of the Medicare program.
- (5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

**What factors should be considered when determining to elect COBRA continuation coverage?** You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. Second, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

**What is the procedure for obtaining COBRA continuation coverage?** The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

**What is the election period and how long must it last?** The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information.

The Trade Act of 2002 also created a new tax credit for certain TAA-eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at [www.doleta.gov/tradeact](http://www.doleta.gov/tradeact).

**Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?** The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- (1) the end of employment or reduction of hours of employment,
- (2) death of the employee,
- (3) commencement of a proceeding in bankruptcy with respect to the employer, or
- (4) enrollment of the employee in any part of Medicare.

**IMPORTANT:**

**For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Sponsor.**

**NOTICE PROCEDURES:**

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Washtenaw County Road Commission  
555 North Zeeb Road  
Ann Arbor, Michigan 48103

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives ***timely notice*** that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

**Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?** If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

**Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?** Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

**When may a Qualified Beneficiary's COBRA continuation coverage be terminated?** During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- (1) The last day of the applicable maximum coverage period.
- (2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

- (3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.
- (4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- (5) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
- (6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
  - (a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
  - (b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

**What are the maximum coverage periods for COBRA continuation coverage?** The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

- (1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
- (2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:
  - (a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or
  - (b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.
- (3) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
- (4) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

**Under what circumstances can the maximum coverage period be expanded?** If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month

period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the Plan Sponsor in accordance with the procedures above.

**How does a Qualified Beneficiary become entitled to a disability extension?** A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the Plan Sponsor in accordance with the procedures above.

**Does the Plan require payment for COBRA continuation coverage?** For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

**Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?** Yes. The Plan is also permitted to allow for payment at other intervals.

**What is Timely Payment for payment for COBRA continuation coverage?** Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

#### **IF YOU HAVE QUESTIONS**

If you have questions about your COBRA continuation coverage, you should contact the Plan Sponsor. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

#### **KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES**

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

## RESPONSIBILITIES FOR PLAN ADMINISTRATION

**PLAN ADMINISTRATOR.** Washtenaw County Road Commission Dental and Vision Plan is the benefit plan of Washtenaw County Road Commission, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual may be appointed by Washtenaw County Road Commission to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, Washtenaw County Road Commission shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

### DUTIES OF THE PLAN ADMINISTRATOR.

- (1) To administer the Plan in accordance with its terms.
- (2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
- (3) To decide disputes which may arise relative to a Plan Participant's rights.
- (4) To prescribe procedures for filing a claim for benefits and to review claim denials.
- (5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
- (6) To appoint a Claims Processor to pay claims.
- (7) To perform all necessary reporting as required by ERISA.
- (8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.
- (9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

**PLAN ADMINISTRATOR COMPENSATION.** The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

**FIDUCIARY.** A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

**FIDUCIARY DUTIES.** A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

- (1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;
- (2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
- (3) in accordance with the Plan documents to the extent that they agree with ERISA.

**THE NAMED FIDUCIARY.** A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

- (1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or
- (2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

**CLAIMS PROCESSOR IS NOT A FIDUCIARY.** A Claims Processor is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

**COMPLIANCE WITH HIPAA PRIVACY STANDARDS.** Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

- (1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.
- (2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.
- (3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.
  - (a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.
  - (b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.
  - (c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the

Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

- (i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
- (ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;
- (iii) Mitigating any harm caused by the breach, to the extent practicable; and
- (iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

**(4) Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:

- (a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;
- (b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
- (c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
- (d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;
- (e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;
- (f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
- (g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;
- (h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
- (i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which 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 unfeasible; and
- (j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of Washtenaw County Road Commission's workforce are designated as authorized to receive Protected Health Information from Washtenaw County Road Commission Dental and Vision Plan ("the Plan") in order to perform their duties with respect to the Plan: Human Resource Director.

**COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS.** Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

- (1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
- (2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
- (3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

### **FUNDING THE PLAN AND PAYMENT OF BENEFITS**

The cost of the Plan is funded as follows:

**For Employee and Dependent Coverage:** Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Processor.

### **PLAN IS NOT AN EMPLOYMENT CONTRACT**

The Plan is not to be construed as a contract for or of employment.

### **CLERICAL ERROR**

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

### **AMENDING AND TERMINATING THE PLAN**

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

### **CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA**

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

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

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

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

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

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

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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

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

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

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

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Plan Participant should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at [www.dol.gov/ebsa/](http://www.dol.gov/ebsa/). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

## GENERAL PLAN INFORMATION

### TYPE OF ADMINISTRATION

The Plan is a self-funded Plan and the administration is provided through a Third Party Claims Processor. 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

Washtenaw County Road Commission Dental and Vision Plan

**PLAN NUMBER:** 200

**TAX ID NUMBER:** 38-2047348

**PLAN EFFECTIVE DATE:** January 1, 2006

**PLAN YEAR ENDS:** December 31

### EMPLOYER INFORMATION

Washtenaw County Road Commission  
555 North Zeeb Road  
Ann Arbor, Michigan 48103  
734-761-1500

### PLAN ADMINISTRATOR

Employer is the Plan Administrator  
Washtenaw County Road Commission  
555 North Zeeb Road  
Ann Arbor, Michigan 48103  
734-761-1500

### NAMED FIDUCIARY

Washtenaw County Road Commission  
Washtenaw County Road Commission  
555 North Zeeb Road  
Ann Arbor, Michigan 48103

### AGENT FOR SERVICE OF LEGAL PROCESS

Washtenaw County Road Commission  
Washtenaw County Road Commission  
555 North Zeeb Road  
Ann Arbor, Michigan 48103

### CLAIMS PROCESSOR

Professional Benefits Services  
2959 Luceren SE, Suite 205  
Grand Rapids, Michigan 49546  
616-285-2480 or 1-800-732-3412

BY THIS AGREEMENT, Washtenaw County Road Commission Dental and Vision Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Washtenaw County Road Commission on or as of the day and year first below written.

By \_\_\_\_\_  
Washtenaw County Road Commission

Date \_\_\_\_\_