

WHATCOM COUNTY DENTAL REIMBURSEMENT PLAN

SUMMARY PLAN DESCRIPTION

Effective January 1, 2014

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DENTAL REIMBURSEMENT PLAN

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Introduction

Whatcom County is pleased to establish this Dental Reimbursement Plan to provide you with dental benefits. The benefits available under this Plan are outlined in this summary plan description. We will also tell you about other important information concerning the Plan, such as the rules you must satisfy before you become eligible and the laws that protect your rights.

Read this summary plan description carefully so that you understand the provisions of our Plan and the benefits you will receive. You should direct any questions you have to the Administrator. There is a plan document on file, which you may review if you desire. In the event there is a conflict between this summary plan description and the plan document, the plan document will control.

I - Eligibility

1. What Are the Eligibility Requirements for Our Plan?

Employees are eligible to participate if they are in a benefit eligible position upon completion of one month of 80+ hours of employment. Eligible dependents are legal spouses and children. Dependent children are covered up to age 26.

2. When is My Entry Date?

Once you have met the eligibility requirements, your entry date will be the first day of the month following the date you met the eligibility requirements.

3. Are There Any Employees Who Are Not Eligible?

Yes, there are certain employees who are not eligible to join the Plan. They are:

- a represented employee
- classified by Whatcom county as an independent contractor
- a leased employee (including but not limited to those individuals defined in Section 414(n) of the Internal Revenue Code).

4. Dependent Eligibility

Coverage under this plan is available to eligible employees and dependents. For purposes of this plan, eligible dependents are:

- The subscriber's husband or wife.
- The subscriber's natural child, adopted child, or step-child, up to age 26.

5. Enrollment in the Plan

You must complete a Direct Reimbursement Dental Plan Enrollment Form to enroll you and your dependents in this plan.

6. Changes in Eligible Dependents

If your marital status changes, you acquire a dependent either through adoption placement for adoption, birth of a child or marriage, or your dependents are no longer eligible for coverage, you are responsible for submitting an enrollment form with the new information to Whatcom County Human Resources within 60 days of the event.

II - Benefits

1. What Benefits Are Available?

Dental Benefit: Dental expenses will be reimbursed as indicated below for each enrolled participant:

- 100% of the first \$250
- 80% of the next \$500
- 50% of the next \$1,700

Maximum Annual Dental Benefit: \$1,500

Orthodontia Benefit: Orthodontia expenses will be reimbursed at 70% up to a lifetime maximum of \$1,500 per enrolled participant.

Eligible Expenses: Examples of eligible dental expenses include routine cleanings, exams, x-rays, fillings, crowns. Examples of ineligible dental expenses include expenses that are primarily cosmetic or hygienic in nature, such as teeth whitening, veneers, or toothbrushes. Eligible expenses must be incurred during the plan year. Orthodontia services are considered to be incurred on the date a payment is made while dental services are incurred on the date the service is rendered. Proof of payment is not necessary for reimbursement of dental expenses.

You may submit expenses for yourself, spouse and qualified dependents. You may be reimbursed for expenses for any child until the end of the month in which the child reaches age 26. A child is a natural child, stepchild, foster child, adopted child, or a child placed with you for adoption.

Coordination of Benefits

Only medical care expenses that have not been reimbursed or those for which you will not seek reimbursement from any other source may qualify as Eligible Dental Expenses (to the extent all other conditions for Eligible Dental Expenses have been satisfied). As such, this Dental Reimbursement Plan does not coordinate benefits with any other group or individual health coverage except as provided herein.

If you are also a participant in a Health Care FSA sponsored by your Employer, you must first use all amounts in the Dental Reimbursement Plan before being reimbursed by the Health Care Flexible Spending Account or Health Savings Account.

2. When Must Expenses Be Incurred?

You may submit expenses that you incur each “Plan Year.” A new “Plan Year” begins each year on January 1st. If you become eligible after the start of the “Plan Year” you may only claim services incurred since your eligibility date.

Dental expenses are considered “incurred” when the service is performed, not necessarily when it is paid for. Orthodontia services are considered “incurred” on the date a payment is made. Any amounts reimbursed to you under the Plan may not be claimed as a deduction on your personal income tax return nor reimbursed by other health plan coverage including a Health Care Flexible Spending Account.

3. When Will I Receive Payments From the Plan?

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. However, you must make your requests for reimbursements no later than 90 days after the end of the Plan Year. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. In addition, you must submit to the Administrator proof of the expenses you have incurred and that they have not been paid by any other health plan coverage. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, reimbursements made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes.

4. What Happens If I Terminate Employment?

If your employment is terminated during the Plan Year for any reason, your participation in the Plan will cease. You will have 90 days after your date of benefits termination to turn in claims for expenses that were incurred prior to your date of benefits termination. You may be eligible to maintain coverage under COBRA, see subsection V for more information.

Termination of Participant

Unless you contribute premiums for continued participation as required by COBRA, you and your dependents’ coverage under this plan shall terminate on the earliest of the following dates:

- The last day the month following the final month in which hours worked requirements are not satisfied. you do not receive at least 80 hours of compensation.
- The date of termination of the Plan
- The date all or certain benefits are terminated for your particular class by modification of the plan.
- The date you become a full-time member of the armed forces of any country.
- The date you fail to make a required contribution, if any.

If any of the above situations occur, you must submit your claims for reimbursement no later than three (3) months after the end of the month in which your employment

terminated. However, if the Plan terminates, your claims must be submitted for reimbursement no later than three (3) months after the date of termination.

5. Family and Medical Leave Act (FMLA)

If you go on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA) then to the extent required by FMLA, the Employer will continue to maintain Dental Reimbursement Plan benefits on the same terms and conditions as if you were still an active Eligible Employee.

6. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage under your Dental Reimbursement Plan under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask your Administrator for further details.

7. Qualified Medical Child Support Order

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a participant. The child becomes an "alternate recipient" and can receive benefits under the health plans of the Employer, if the order is determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Plan Administrator.

8. Overpayments and Fraud

If it is later determined that you and/or your covered dependent(s) received an overpayment or a payment was made in error (e.g., you were reimbursed for an expense under the Dental Reimbursement Plan that is later paid for by the corresponding dental plan or some other medical plan), you will be required to refund the overpayment or erroneous reimbursement to the Plan.

If you do not refund the overpayment or erroneous payment, the Plan reserves the right to offset future reimbursement equal to the overpayment or erroneous payment or, if that is not feasible, withhold such funds from your pay. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may include the amount on your W-2 as gross income.

The Plan Administrator may audit the plan to detect fraud or material misrepresentations of fact for health care operations and plan administration functions. Fraudulent claims are not protected health information because they do not relate to the health condition of an individual. Examples of fraudulent claims include claims for services not rendered or claims for services rendered by a provider that does not exist. In the event fraudulent claims are discovered the participant will be required to refund the payment to the Dental Reimbursement Plan. If the participant fails to refund the overpayment, the Plan

Administrator reserves the right to offset future reimbursements or withhold such funds from the participant's income. In addition, if the Plan Administrator determines that you have submitted a fraudulent claim, the Plan Administrator may terminate your coverage under this Plan. The Employer may also take any and all action permitted by state and federal law

III - General Information About Our Plan

This Section contains certain general information which you may need to know about the Plan.

1. General Plan Information

Whatcom County is the name of the Plan.

Your Employer has assigned Plan Number 502 to your Plan.

The provisions of your Plan become effective on January 1, 2005.

The provisions of your Plan have been amended as of January 1, 2014.

2. Employer Information

Your Employer's name, address, and identification number are:

Whatcom County
311 Grand Avenue Suite 107
Bellingham, WA 98225
Tax ID# 91-6001383

3. Plan Administrator Information

The name, address and business telephone number of your Plan's Administrator are:

Whatcom County 311 Grand Avenue Suite 107
Bellingham, WA 98225
(360) 778-5300

The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about our Plan. The Plan Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding. You may contact the Administrator for any further information about the Plan.

4. Third Party Claims Administrator Information

The name, address and business telephone number of the Third Party Claims Administrator are:

Flex-Plan Services, Inc.
PO Box 53250
Bellevue, WA 98015-3250
866-897-1996

The Third Party Claims Administrator is responsible for the actual processing of claims on behalf of the Plan Administrator.

5. Service of Legal Process

The Employer is the Plan's agent for service of legal process.

6. Type of Administration

The Plan is a Dental Reimbursement Plan and the administration is provided through a Third Party Claims Administrator. The Plan is not funded or insured. Benefits are paid from the general assets of the Employer.

IV - Additional Plan Information

1. How to Submit a Claim

When you have a Claim to submit for payment, you must:

- Obtain a claim form from the Plan Administrator.
- Complete the Employee portion of the form.
- Attach itemized copies of all bills and/or Explanation of Benefits (EOB) for which you are requesting reimbursement.

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.

Notification of whether Claim is accepted or denied 30 days

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

Denial or insufficient information on the Claim:

Notification of 15 days

Response by Participant 45 days

Review of Claim denial 30 days

You must file your appeal by submitting a written request by email, fax, or mail. Indicate either level one or two appeal on the email, fax, or letter.

- Email: 105@flex-plan.com
- Fax: 425-709-7125 or 1-866-831-6222
- Mail: Flex-Plan Services, PO Box 53250, Bellevue WA 98015.

The Plan Administrator will provide written or electronic notification of any Claim denial. The notice will state:

1. The specific reason or reasons for the denial.
2. Reference to the specific Plan provisions on which the denial 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 and the time limits applicable to such procedures.
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; and
6. If the denial 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 denial and a copy will be provided free of charge to the claimant upon request.

A level one appeal must be submitted within 180 days of receipt of the denial. Any such request should be accompanied by documents or records in support of your appeal. You may review pertinent documents and submit issues and comments in writing. The claims administrator will review the claim and provide, within 30 days, a written response to the appeal (extended by reasonable time if necessary). In this response, the claims administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based.

If you disagree with the level one appeal decision you may submit a request for a level two appeal to be determined by the Employer. You must submit your request for level two appeals within 60 days of receipt of the level one notice. You will be notified within 30 days after the Employer receives the appeal (extended by reasonable time if necessary). The Employer has the exclusive right to interpret the appropriate plan provisions. Decisions of the Employer are conclusive and binding.

Under certain circumstances you may have a right to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Contact the claims administrator for more information.

If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

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

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

The review will 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 Claim determination. The review will not afford deference to the initial denial 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.

2. Failure to Cash Reimbursement Checks

Any reimbursement check that remains uncashed for more than one year after it is issued is treated as forfeiture.

3. No Contract of Employment

This plan is not intended to be, and may not be construed as constituting a contract or other arrangement between you and Whatcom County to the effect that you will be employed for any specific period of time. Nothing in this Plan shall be deemed to give any employee the right to be retained in the service of Whatcom County or to interfere with Whatcom County's right to terminate any employee at any time.

4. Limitations of Liability

Nothing in or omitted from this plan is to be construed as a promise by Whatcom County to perform any dental or orthodontic service. In no case will Whatcom County be liable for the negligence or other wrongful act or omission of any dental care provider, hospital, facility or institution, or their employees or any other person.

Whatcom County's liability will be limited to the allowed amount for the benefits covered under this plan. Whatcom County's liability will not include any liability for pain and suffering or general damages.

5. Severability

If any provision of this plan is determined to be invalid, all other provisions of this plan shall remain in effect.

V - CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain employees and their families covered under this Arrangement will be entitled to the opportunity to elect a temporary extension of health coverage (called “COBRA continuation coverage”) where coverage under the Arrangement would otherwise end. This notice is intended to inform 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 or its designee 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 Participants who become Qualified Beneficiaries under COBRA. The Arrangement itself can provide group health benefits and may also be used to provide health benefits through insurance. Whenever “Arrangement” is used in this section, it means any of the health benefits under this Plan.

1. What is COBRA Continuation Coverage?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain 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 Arrangement (the “Qualifying Event”). The coverage must be identical to the 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).

2. 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 the Arrangement 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 Arrangement 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 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 Arrangement 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 Arrangement 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 coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term “covered Employee” includes any individual who is provided coverage under the Arrangement due to his or her performance of services for the employer sponsoring the Arrangement. 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.

3. What is a Qualifying Event?

A Qualifying Event is any of the following if the Arrangement provided that the 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:

- The death of a covered Employee.
- The termination (other than by reason of the Employee’s gross misconduct), or reduction of hours, of a covered Employee’s employment.
- 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.
- A Dependent child’s ceasing to satisfy the Arrangement’s requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Arrangement)

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 Arrangement under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Arrangement occurring within 12 months before or after the date the bankruptcy

proceeding commences), 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 Arrangement 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 Arrangement 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 Arrangement during the FMLA leave.

4. 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. 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.

5. What is the Procedure for Obtaining COBRA Continuation Coverage?

The Arrangement 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.

6. 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 Arrangement. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 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.

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 or she and/or his or her family members may qualify for assistance under this special provision should contact the Plan Administrator or its designee for further information.

7. Is a Covered Employee or Qualified Beneficiary Responsible for Informing the Plan Administrator of the Occurrence of a Qualifying Event?

The Arrangement 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 will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- the end of employment or reduction of hours of employment,
- death of the employee,
- commencement of a proceeding in bankruptcy with respect to the Employer, or
- 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 Administrator or its designee.

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:

*Whatcom County
311 Grand Avenue Suite 107
Bellingham, WA 98225*

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 coverage would otherwise have been lost (if under your coverage the COBRA period begins on the date of the Qualifying Event, even though coverage actually ends later (e.g., at the end of the month) substitute the appropriate language, e.g. “on the date of the Qualifying Event”). 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.

8. 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.

9. 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).

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

11. 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.

12. 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 Administrator or its designee and in accordance with the procedures above.

13. 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 must be sent to the Plan Administrator or its designee and in accordance with the procedures above.

14. Does the Arrangement Require Payment for COBRA Continuation Coverage?

For any period of COBRA continuation coverage under the Arrangement, Qualified Beneficiaries who elect COBRA continuation coverage may be required to 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. Your Plan Administrator will inform you of any costs. The Arrangement will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

15. Must the Arrangement Allow Payment for COBRA Continuation Coverage to Be Made in Monthly Installments?

Yes. The health coverage is also permitted to allow for payment at other intervals.

16. 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 Arrangement by a later date is also considered Timely Payment if either under the terms of the Arrangement, 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 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 Arrangement 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 those providing coverage.

If Timely Payment is made to the Arrangement in an amount that is not significantly less than the amount the Arrangement requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Arrangement's requirement for the amount to be paid, unless the Arrangement 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.

17. Must a Qualified Beneficiary Be Given the Right to Enroll in a Conversion Health Plan at the End of the Maximum Coverage Period for COBRA Continuation Coverage?

If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Arrangement will, during the 180 day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the

Arrangement. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its designee. For more information about your rights under 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 Web site at 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 or its designee.

APPENDIX I TO THE DENTAL REIMBURSEMENT PLAN SUMMARY PLAN DESCRIPTION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This summary applies to all of the personal health information we maintain with regard to the Plan. Your doctor or health care provider will have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic. During the course of providing you with coverage under the Plan, the Plan will have access to information about you that is deemed to be "protected health information", or PHI, by the Health Insurance Portability and Accountability Act of 1996, or HIPAA. The following is a summary of procedures adopted by the Employer to ensure that both Employer and any third party service providers treat your PHI with the level of protection required by HIPAA.

This summary will provide you with a general overview of the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

Your PHI will be disclosed to certain employees of Employer who assist in administration of the Plan. These individuals may only use your PHI for Plan administration functions including those described below, provided they do not violate the provisions set forth herein. Any employee of Employer who violates the rules for handling PHI established herein will be subject to adverse

disciplinary action. Employer will establish a mechanism for resolving privacy issues and will take prompt corrective action to cure any violations.

By adoption of the SPD, Employer has certified that it will comply with the privacy procedures summarized herein and detailed in any separate privacy notice. Employer may not use or disclose your PHI other than as summarized herein or as required by law. Any agents or subcontractors who are provided your PHI must agree to be bound by the restrictions and conditions concerning your PHI found herein. Your PHI may not be used by Employer for any employment-related actions or decisions or in connection with any other benefit or employee benefit plan of Employer. Employer must report to the Plan any uses or disclosures of your PHI of which the Employer becomes aware that are inconsistent with the provisions set forth herein.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information for purposes of Plan administration. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment (as described in applicable regulations). We may use and disclose medical information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage.

For Health Care Operations (as described in applicable regulations). We may use and disclose medical information about you for other Plan operations. These uses and disclosures are necessary to run the Plan.

As Required By Law. We will disclose medical information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

Disclosure to Health Plan Sponsor. Information may be disclosed to another health plan maintained by Employer for purposes of facilitating claims payments under that plan. In addition, medical information may be disclosed to Employer personnel solely for purposes of administering benefits under the Plan.

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities.

Workers' Compensation. We may release medical information about you for workers' compensation or similar programs.

Public Health Risks. We may disclose medical information about you for public health activities (e.g., to prevent or control disease, injury, or disability).

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official for law enforcement purposes.

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to Personnel/Benefits Office, except as otherwise set forth in any separate Privacy Notice provided to you by Employer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. HIPAA provides several important exceptions to your right to access your PHI. For example, you will not be permitted to access psychotherapy notes or information compiled in anticipation of, or for

use in, a civil, criminal, or administrative action or proceeding. Employer will not allow you to access your PHI if these or any of the exceptions permitted under HIPAA apply. If you are denied access to medical information, you may request that the denial be reviewed.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to your human resources department. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Is not part of the medical information kept by or for the Plan;
- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Employer must act on your request for an amendment of your PHI no later than 60 days after receipt of your request. Employer may extend the time for making a decision for no more than 30 days, but it must provide you with a written explanation for the delay. If Employer denies your request, it must provide you a written explanation for the denial and an explanation of your right to submit a written statement disagreeing with the denial.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" (other than disclosures you authorized in writing) where such disclosure was made for any purpose other than treatment, payment, or health care operations. You will be notified of where you can obtain an accounting of disclosure in the separate Privacy Notice. Your request must state a time period that may not be longer than six years and may not include dates before April 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Note that HIPAA provides several important exceptions to your right to an accounting of the disclosures of your PHI. For example, Employer does not have to account for disclosures of your PHI (i) to carry out treatment, payment or healthcare operations, (ii) to correctional institutions or law enforcement officials, or (iii) for national security or intelligence purposes. Employer will not include in your accounting any of the disclosures for which there is an exception under HIPAA. Employer must act on your request for an accounting of the disclosures of your PHI no later than 60 days after receipt of the request. Employer may extend the time for providing you an accounting by no more than 30 days, but it must provide you a written

explanation for the delay. You may request one accounting in any 12-month period free of charge. Employer will impose a fee for each subsequent request within the 12-month period.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to your human resources department. We will not ask you the reason for your request. We will accommodate all requests we deem reasonable. Your request must specify how or where you wish to be contacted.

When Employer no longer needs PHI disclosed to it by the Plan, for the purposes for which the PHI was disclosed, Employer must, if feasible, return or destroy the PHI that is no longer needed. If it is not feasible to return or destroy the PHI, Employer must limit further uses and disclosures of the PHI to those purposes that make the return or destruction of the PHI infeasible.

CHANGES TO THIS SUMMARY AND THE SEPARATE PRIVACY NOTICE

We reserve the right to change this summary and the separate Privacy Notice that may be provided to you. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. The notice will contain the effective date on the front page.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact your human resources department except as otherwise provided in any separate Privacy Notice. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION.

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided to you.