



**GWINNETT
COUNTY
PUBLIC
SCHOOLS**

**Direct Reimbursement Plan
Dental Benefits**

*Summary Plan Description
Effective January 1, 2025*

Introduction

The Gwinnett County Public Schools Dental Plan, effective January 1, 2025, is designed to provide you dental benefits that you contribute to with tax-free dollars.

This booklet provides the Summary Plan Description (SPD) of the Gwinnett County Public Schools Dental Plan, referred to in this booklet as the "Plan." It is intended to explain only the major provisions of the Plan as of January 1, 2025. If there ever should be a conflict between this booklet and the contracts and documents that control the Plan, the Plan contracts and documents will govern in all cases.

The benefits described in this booklet are for eligible employees of Gwinnett County Public Schools (the Company). Employees may choose coverage between the Basic Plan or the Premium Plan levels of benefit under the Plan.

Eligibility for, or participation in, the Plan does not constitute a guarantee of employment, nor does it interfere with Gwinnett County Public Schools' right to terminate employment.

Gwinnett County Public Schools currently intends to continue the Plan as described in this booklet, but reserves the right, in its discretion, to amend, reduce or terminate the Plan and coverage at any time, with or without notice to participants.

Gwinnett County Public Schools will update this booklet periodically to describe changes in the Plan, but there may be a delay between the effective date of a Plan change and the date you receive a description of the change. You should contact your Human Resources Department if you have questions about coverage *before* you incur expenses.

Dental Claims Administrator: MetLife

Gwinnett County Public Schools has contracted with MetLife for claims administration. You can contact MetLife at 1-800-942-0854 (Customer Service) or at their website www.metlife.com/mybenefits to find out specific information regarding claim payments, Explanation of Benefits (EOB) and other data applicable to your benefit.

Dental Benefits at a Glance

The chart below summarizes the Gwinnett County Public Schools Dental Plan, based on the option you elect. More details are provided throughout this booklet. You are encouraged to read this booklet carefully and, if you are married, have your spouse read it as well. If you are a late entrant into the dental plan, please see the late entrant section on the following page.

	Basic Plan Benefits	Premium Plan Benefits
Dental Expenses	<ul style="list-style-type: none"> • 100% of the first \$225 of covered expenses, then... • 0% of the next \$75 of covered expenses, then... • 50% of remaining covered expenses, up to an annual maximum benefit per person of \$750. 	<ul style="list-style-type: none"> • 100% of the first \$250 of covered expenses, then... • 0% of the next \$75 of covered expenses, then... • 50% of remaining covered expenses, up to an annual maximum benefit per person of \$1,500.
Orthodontia Expenses	Not Covered	Covered*

* Payment for orthodontic treatment is made in installments and is subject to the schedule of benefits and annual plan maximum described above. The first orthodontic claim, or down payment, is payable on the date braces are placed. The down payment may be up to a maximum of 25% of the estimated charge of the dentist or PDP fee (total treatment charge). Future monthly treatments/adjustments are determined by taking the balance of the estimated treatment charge, divided by the total number of treatment months. **It is your responsibility to provide proof of continuation of treatment in order to receive reimbursement each month. The Plan does not allow for lump sum payments.**

All benefits are based on a calendar year and apply separately for each covered person.

Enrolling and Changing Dental Benefits

New Enrollees – Plan Options

As a new employee you are eligible to enroll in Gwinnett County Public Schools' Dental Plan. This plan election will remain in effect for the Plan Year. You can change or revoke your election during the Plan Year only if you have a qualifying event.

Late Entrants – Dental Benefits

If you decline coverage when you are first eligible to enroll, and then elect coverage later, you will be considered a late entrant unless you can provide proof of prior dental coverage. Proof of prior coverage must be submitted within 31 days of enrollment. Late entrants receive reduced dental benefits for the first calendar year of coverage. If coverage is dropped during annual enrollment and then you re-enroll during the next enrollment period, you will be considered a late entrant and receive reduced benefits unless proof is provided of prior dental coverage. For each late entrant, the Plan will pay 50% of covered expenses incurred during the calendar year. The maximum benefit per person is one half the normal benefits for the basic and premium Plans or \$375 for the **BASIC Plan** and \$750 for the **PREMIUM Plan** for all covered services.

Duplicate Benefits

No person may be covered under the plan as both an employee and a dependent. Dependents under this plan cannot be covered under the plan by more than one employee.

Basic/Premium Plan Election Changes

Your election to receive coverage under the Plan will remain in effect for the Plan Year. If you are a new employee and elected coverage during a period other than the open enrollment period, your initial election will remain in effect from the date your election became effective until the following Plan Year. If you do not complete a new election form for coverage during the next annual enrollment period, your election automatically will remain in effect for the next Plan Year.

You may change or revoke your election during the middle of a Plan Year only if you experience a qualifying event and the change in coverage on account and consistent with the qualifying event.

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Section 1. Eligibility

Employees

You are an eligible employee for the benefits described in this booklet if you are an employee who routinely works at least 20 hours per week in a board approved position.

Dependents

Your eligible dependents may also be covered. Eligible dependents are:

- Your Spouse
- Children under 19 years (under 26 if a full-time student*), which includes
 - Natural/biological child;
 - Adopted child (including a child from the date of placement with the adopting parent until the legal adoption);
 - Stepchild (provided employee and child's parent are legally married; and
 - Child that you have legal guardianship.

*at an accredited school, college or university that is licensed in the jurisdiction where it is located. A full-time student includes a child who is so enrolled for at least five months in each calendar year, or a child who, as a result of being injured or ill, is prevented from being so enrolled, but would otherwise have been enrolled.

• You can elect individual coverage (which covers you), or you can elect family coverage (which covers you and all of your eligible dependents). However, if you are divorced or separated from your spouse, you may be required under the terms of a "Qualified Medical Child Support Order" to provide coverage under the Plan to any of your children named in such order. A Qualified Medical Child Support Order ("QMCSO") is an order requiring a health (or dental) plan to recognize the child of a parent-employee as a plan participant. If the Plan Administrator receives a QMCSO for an employee who is not presently enrolled in the Plan, the employee will be enrolled in family coverage. The Plan's QMCSO procedures are available from the Plan Administrator upon request at no charge to you.

Incapacitated Children

Coverage may be available for an incapacitated child past the age limitations noted above. To continue coverage, the child must be mentally or physically incapacitated. It is the employee's responsibility to send written proof to MetLife that the child is handicapped and depends on the employee for most of his/her support and maintenance within 31 days from the date the child reaches the age limit. MetLife will notify the employee if the continued coverage for the child has been approved. The employee may be asked for periodic proof that the child's condition continues. The child's coverage ends when the employee's coverage ends.

Newborn Children

Late entrant penalties will not apply to the following:

- Dependent children added within 90 days from date of birth; or
- Dependent children up to age 4 may be added to the Plan within 31 days of their birthday and will not be subject to the late entrant provision.

Enrollment

If you want to cover yourself or your dependents under the Plan, you must:

- Apply for the coverage on the proper form; and
- Agree in writing to make the required contributions.

Prior to the first day of each Plan Year, the Plan will provide an annual enrollment period during which you may elect to be covered under the Plan or, if you are already covered, to change the type of coverage (for example, from individual to family coverage). No person may be covered as a dependent of more than one employee.

Section 2. When Coverage Begins

The coverage that you elect during the annual enrollment period will become effective on the first day of the Plan Year following the annual enrollment period. If you become employed during the Plan Year and you elect coverage during a period other than the open enrollment period, your coverage will be effective on the first day of the month following completion of one month of employment in which you are regularly scheduled to work at least 20 hours per week.

Enrollment Changes During the Year

You may change or revoke your election during the middle of a Plan Year only if you experience a qualifying event and the change in coverage is on account of and consistent with the qualifying event. This change must be made within 31 days of the qualifying event. Except this timeframe is extended to 60 days for Child's Medicaid or CHIP/SCHIP coverage termination or employee/child becoming eligible for premium assistance or 90 days for death of dependent, birth, adoption or placement for adoption.

A Qualifying Event is:

- marriage, divorce or legal separation
- the birth, legal guardianship or adoption of a child (*changes due to this qualifying event must be made within 90 days*)
- the death of a dependent (*changes due to this qualifying event must be made within 90 days*)
- a dependent who either becomes eligible for coverage or is no longer eligible
- a change in spouse's employment
- the receipt of a qualified medical child support order
- a "special enrollment period," as required under the Internal Revenue Code
- any other event deemed a "qualifying event" by the Plan Administrator, in accordance with applicable law.

The effective date of qualifying event enrollment changes will be based on (a) the date of the qualifying event, and (b) the date you notify the plan of the qualifying event. Documentation of the above events will be required before enrollment can be accepted, and must be received no later than 31, 60 or 90 calendar days of the respective qualifying events above.

Annual Enrollment Period

Toward the end of each calendar year, there will be an annual enrollment period. During the annual enrollment period, you may change your previous enrollment decisions. For example, if you did not enroll when you first became an eligible employee, you may enroll at this time. Or, if you enrolled for coverage for yourself only but you want to add your dependents, you may do so during an annual enrollment period. If you (or your dependents) do not enroll in the Plan when you (or your dependents) first become eligible to participate, you (or your dependents) will be referred to as a "late entrant." Late entrants are subject to reduced benefits under the Plan.

Annual Enrollment changes also include dropping dependent coverage and changing from one option to the other. You cannot change your plan design option during the calendar year. If you do not elect coverage during the next annual enrollment period, your election will automatically remain in effect for the next Plan Year.

Once your coverage begins, you may not change your coverage decisions until the next annual enrollment period unless you have a qualifying event.

Dependent Coverage

Dependent coverage will begin on the same date as your coverage, provided you have enrolled your dependents and supplied the appropriate documentation of their eligibility (such as a marriage certificate for a spouse, or a birth certificate or adoption certificate for a child).

Retired Employees

Retirees are covered under the Basic and Premium Plan. They can only elect the coverage they had prior to retirement. If they did not have dental coverage prior to retirement, they cannot enroll once retired.

Section 3. Cost

The coverage under this Plan is contributory, meaning the employee pays all or a portion of the cost.

How much you pay depends on whether you elect the Basic or Premium Plan and whether you cover:

- yourself only; or
- yourself and your eligible dependents.

Your benefits administrator will tell you the cost of your coverage when you enroll. Your cost will be paid on a before-tax basis by the amount required to pay for the type of coverage you elected. This means your cost of the coverage will be deducted from your gross pay before federal and, in most cases, state and city taxes are withheld. Your income taxes and Social Security taxes will be determined on the remaining pay. Therefore, you will be lowering your taxes by paying for coverage this way.

If your contributions for coverage change, your benefits administrator will notify you, in advance.

Section 4. How the Plan Works

This Plan is a dental expense reimbursement plan that will provide for payment of services to either you or your providers while you are covered under the Plan for allowable expenses. This means that you may pay the provider for supplies and services you or a covered family member receives, then request reimbursement from the Plan; or you may assign the payment directly to the provider.

You are not restricted to specific providers. You may use the dental provider of your choice. For dental services, there are discounts available if you choose a provider in the MetLife Dental Network. Covered expenses include treatment by any licensed provider.

How Much the Plans Pay

How much the Plans cover depends on which option you elect: the **Basic Plan** or the **Premium Plan**.

The Basic Plan

The Basic Plan will cover expenses incurred in the same calendar year as follows:

- **First:** The Plan pays 100% of the first \$225 of covered expenses.
- **Second:** You pay the next \$75 of covered dental expenses.
(You will not be reimbursed for this \$75 of covered expenses.)
- **Third:** The Plan will then pay 50% of the remaining expenses up to a maximum benefit of \$750.

The Premium Plan

The Premium Plan will cover expenses incurred in the same calendar year as follows:

- **First:** The Plan pays 100% of the first \$250 of covered expenses.
- **Second:** You pay the next \$75 of covered dental expenses.
(You will not be reimbursed for this \$75 of covered expenses.)
- **Third:** The Plan will then pay 50% of the remaining expenses up to a maximum benefit of \$1,500.

Benefit Maximums

The Basic Plan and the Premium Plan have a calendar year benefit maximum. This maximum is the most the Plan will pay for expenses incurred during the same calendar year.

- **Basic Plan:** For the Basic Plan, the benefit maximum is \$750. However, if you decline coverage when you are first eligible and then elect coverage later, the Dental benefit maximum will be reduced to \$375 during the first calendar year of coverage. (See Late Entrant section)
- **Premium Plan:** For the Premium Plan, the benefit maximum is \$1,500. However, if you decline coverage when you are first eligible and then elect coverage later, the Dental benefit maximum will be reduced to \$750 during the first calendar year of coverage. (See Late Entrant section)

Section 4. How the Plan Works

Covered Expenses

All care must be completed by a licensed dentist to be eligible for coverage under the Plan. The following are typical dental expenses covered by the Plan:

- Preventive dental services (oral exams, dental prophylaxis (excluding periodontal cleanings), fluoride treatments (excludes take-home applications) dental x-rays, sealant application, space maintainers);
- Fillings;
- regular extractions (erupted and visible). Other extractions should be filed under the Health Care Plan;
- Oral surgery for impacted wisdom teeth and associated anesthesiologist charges will only be paid under dental if they are first submitted to the medical carrier and denied by any company-sponsored health care plan; and the EOB (Explanation of Benefits) statement of denial from the health care plan is submitted with the claim. Please note that any claim submitted without the EOB denial from a health care plan will be denied;
- Root canal therapy;
- Crowns and bridges;
- Dentures (when care is provided by a licensed dentist); and
- Orthodontics.
 - Typically orthodontics benefits are paid based on the financial agreement made between the Employee and the Dental office. The financial arrangement usually consists of an initial down payment fee and is payable on the date the braces are placed. The down payment is determined by taking up to a maximum of 25% of the total treatment cost or the down payment fee (if billed separately on the claim form). The balance of the total treatment charge is then prorated and paid on a monthly basis during the anticipated months of the treatment. The monthly payment is determined by taking the balance of the estimated total treatment charge or the monthly treatment cost (if indicated on the claim form), divided by the total number of treatment months. Other amounts for other services that have been reimbursed thus far will be taken into consideration. Once the annual maximum of \$1,500 has been met for the year no additional benefits will be paid for the monthly treatment visits. The following year reimbursement towards the remaining monthly treatment visits will be paid subject to the reimbursement to the appropriate plan percentage.

Expenses Not Covered by the Plans

Services and supplies **not** covered by the Plan are:

- expenses due to injuries or conditions payable through workers' compensation;
- expenses incurred for services, which are covered by a governmental agency;
- expenses incurred for services, which are covered by a company sponsored medical plan;
- expenses incurred for cosmetic dentistry; or bleaching.

How Expenses are Handled for Treatment in Process when Coverage Begins

Expenses for any procedure performed on or after the effective date are covered even if it is a continuation of care begun before the effective date. Coverage for all procedures which began prior to the effective date will be excluded except orthodontic care. Orthodontic expenses for monthly maintenance incurred after the effective date will be allowed.

Section 5. How to File a Claim

When you incur expenses and you have **not** assigned benefits, you should obtain a written statement from your provider that describes the dates of service, the type of treatment and the charge. A request for claim payment should be made on claim forms that are obtained from the Human Resources Department. Properly completed claim forms should be sent directly to the following address following occurrence of the treatment or expense.

Send Dental Claims to:

MetLife Dental Claims
P.O. Box 981282
El Paso, TX 79998-1282

If you have assigned benefits to your provider, he or she will submit the claim on your behalf. The provider must submit an employer-provided claim form indicating benefits have been assigned and a statement of services rendered. Any amounts due to the provider which have not been paid under this Plan are the responsibility of the employee.

All claims for expenses must be submitted **no later than 3 months after the end of the Plan Year in which the expenses were incurred**. The Plan reserves the right to verify all reimbursement requests. A fraudulent claim is grounds for termination of benefits determined within the discretion of the Plan.

The claim form must have the following information:

- the patient's name and date of birth;
- your name (the employee);
- your employee identification number or social security number;
- your residence mailing address; and
- your signature.

You should be aware that at all steps of the claims process, you or your dependent may be represented by another person, who may be, but is not required to be, a lawyer. However, you are responsible for paying the fees and expenses of your representative. Also, The Claims Administrator may require evidence that it considers reasonable to establish that an individual is actually your or your dependent's authorized representative.

Although claims are initially determined by MetLife as the Claims Administrator, Gwinnett County Public Schools as the Plan Administrator retains the right and authority to interpret the Plan's Provisions and to determine final benefits and appeals under the Plan. Gwinnett County Public Schools' determinations and interpretations are final and conclusive.

Section 5. How to File a Claim

Initial Review of your Claim

From the date a claim is filed, The Claims Administrator will have a reasonable period of time, up to 30 days, in which to review the claim and to notify you of its decision on the claim. If an extension of the 30-day period is required due to matters beyond the control of the Plan, The Claims Administrator will notify you in writing, prior to the end of the 30-day period, of the circumstances requiring the extension and the date that The Claims Administrator expects to make a decision. The extension period will be no longer than 15 days. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will have at least 45 days from the receipt of the notice within which to provide the necessary information.

If you or your dependent's claim is partly or entirely denied, you will receive written notice from The Claims Administrator. The notice will explain the reason for the denial, specify the Plan provisions on which the denial is based, describe the appeals procedure and the time limits to appeal the claim. The notice will also inform you if The Claims Administrator relied on any internal rule or guideline when it made its decision and that a copy of the rule or guideline will be provided to you free of charge upon request.

How to Appeal your Claim

If your claim is denied (all or in part), you will be informed of the reason(s) for denial, and you may initiate a review of the claim by contacting the Plan Administrator for further instructions. Under the review procedure, you or your duly authorized representative have the right to request the review by making written application to the Plan Administrator, no later than 60 days following receipt of the properly completed request for review, unless it is necessary to seek additional information, in which case the determination will be made within 120 days. Any request for review not responded to within this period shall be deemed denied.

Notice of the Appeal Decision

The Plan Administrator will notify you of its decision on appeal in writing within a reasonable period of time, which will not exceed 60 days after the date upon which the Administrator received the request for appeal, if your claim is partially or wholly denied. The notification will contain the specific reason or reasons for the denial; reference to the specific Plan provisions upon which the denial was based; a statement that you are 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 for benefits; a statement covering voluntary dispute resolution options.

If an internal rule, guideline, protocol or other similar criterion was relied upon in denying an appeal, the Administrator will either furnish you with a copy of the specific rule, guideline, protocol or other criterion, or provide you with a statement that the rule, guideline, protocol or criterion was relied upon in making the decision, and that copy of these materials will be provided to you free of charge.

Overpayments

This Plan has the right to recover any amount that the Claim Administrator determines to be an overpayment, whether for services received by You or Your Dependents.

An overpayment occurs if the Claim Administrator determines that:

- the total amount paid by this Plan on a claim for Dental Benefits is more than the total of the benefits due to You under this Summary Plan Description; or
- payment this Plan made should have been made by another group plan.

If such overpayment occurs, You have an obligation to reimburse this Plan.

How This Plan Recovers Overpayments

This Plan may recover the overpayment from You by:

- stopping or reducing any future benefits payable for Dental benefits;
- if the overpayment is under \$100 it will automatically be reduced from future claims, this will be for anyone in the family that files a claim and for any dentist that is utilized;
- if the overpayment is over \$100 a letter is sent to the provider with a copy to the employee or if not applicable it is sent to the employee;
- if the first letter is ignored then a second letter is sent in 45 days which advises that future payments will be reduced;
- an employee does have the opportunity to set up a payment plan which must be submitted in writing; if a payment is missed while on the payment plan then future payments will be reduced;
- demanding an immediate refund of the overpayment from You; and

If the overpayment results from this Plan having made a payment to You that should have been made under another group plan, this Plan may recover such overpayment from one or more of the following:

- any other insurance company;
- any other organization; or
- any person to or for whom payment was made.

Section 6. When Coverage Ends

There are several circumstances in which the coverage you have as an active employee can end as explained in this section. However, when coverage through the Plan ends, you or your dependents may be eligible for COBRA Coverage (page 16).

Termination of Coverage

When your coverage, as well as that of your dependents, ends on the earliest of the following dates, subject to your right to elect COBRA coverage.

- the date this Plan terminates or is amended to exclude you or your dependents from the class of employees or dependents, as applicable, eligible for coverage;
- the end of the month following the date you are no longer in an eligible class of employees or, with respect to a dependent's coverage, end of the month following the date the dependent is no longer an eligible dependent*;
- the end of the month following the last payroll deduction;
- the date of your death*;
- the date you fail timely to pay employee-required contributions;
- the date you withdraw from the Plan; or
- If you take a leave of absence pursuant to the Family and Medical Leave Act, ("FMLA"), your elected coverage will be continued by the Plan for the authorized period of leave. You will have the option of paying for your coverage while on leave or upon return to active employment.

*Coverage may be extended to the end of the month following these events, depending on when Gwinnett County Public Schools is notified of the event.

Any expenses that you incur during your period of coverage will be eligible for reimbursement, subject to the terms of the Plan.

Personal Leaves

If you take a leave of absence pursuant to the Family and Medical Leave Act, ("FMLA"), your elected coverage will be continued by the Plan for the authorized period of leave. Before your approved leave begins, contact your Human Resources Department on how to pay for this coverage.

When You Die

If you die while covered under this Plan as an employee, your dependent's coverage will end on the later of:

- the last day of the month following the month of your death, or
- the date your salary stops.

Then, when this coverage ends, your dependents may be eligible for COBRA Coverage as explained below.

Section 6. When Coverage Ends

COBRA Coverage

In 1986, a federal law — the Consolidated Omnibus Budget Reconciliation Act (COBRA) — was enacted. COBRA requires that most employers sponsoring group health plans offer employees and their dependents (Qualified Beneficiaries) the opportunity for a temporary extension of health coverage (called “COBRA Coverage”) in certain instances where coverage would otherwise end or change. The following information is intended to inform you, in a summary fashion, of your rights and obligations under COBRA. You, your spouse and your other covered dependents should read this information carefully.

As an employee or retiree covered by the Gwinnett County Public Schools Dental Plan, you have a right to choose COBRA Coverage for yourself and your covered dependents if you lose your coverage or if your coverage changes because of the termination of your employment (for reasons other than gross misconduct on your part) or a reduction in hours, you may elect the same or lesser plan.

As the spouse of an employee or retiree covered by the Plan, you have the right to choose COBRA Coverage for yourself and your covered dependents if your coverage ends or changes for any of the following four events: (1) the death of your spouse (2) a termination of your spouse’s employment (for reasons other than gross misconduct) or reduction in your spouse’s hours of employment; or (3) divorce or legal separation from your spouse (4) your spouse becomes entitled to benefits under Medicare.

In the case of a covered dependent child, he or she has the right to elect COBRA Coverage for himself or herself if coverage ends or changes for any of the following five events: (1) the death of a covered employee or former employee (2) the termination of the covered employee’s employment (for reasons other than gross misconduct) or a reduction in the covered employee’s hours (3) divorce or legal separation (4) the dependent ceases to be a dependent under the provisions of the Plan, or (5) a parent becomes entitled to benefits under Medicare

Effective January 1, 1997 if a child is born to a covered employee, or if a child is under age 18, adopted by or placed for adoption with a covered employee during a period of COBRA continuation coverage, the newborn or adopted child is also a Qualified Beneficiary. These new dependents can be added to COBRA coverage if you notify the Plan Administrator within 30 days of the birth or adoption.

Under the law, the employee or a family member has the responsibility to inform the benefits administrator within 60 days after losing coverage because of a divorce, or legal separation or dependent losing dependent status as defined in Section 1. If this notice is not received within 60 days, the dependent will permanently lose eligibility for COBRA continuation coverage. Gwinnett County Public Schools has the responsibility to notify the appropriate benefits administrator of the employee’s death or termination of employment.

When the benefits administrator is notified that one of these events has happened, you will be notified that you have the right to choose COBRA Coverage. Under the law, you have 60 days from the later of the following two dates to inform the benefits administrator you want COBRA Coverage: (1) the date you would lose coverage or coverage would change because of one of the events described above, or (2) the date the COBRA election form is sent to you.

If you do not choose COBRA Coverage, your coverage will end or change in accordance with the Plan’s provisions and you will not have another opportunity to elect COBRA coverage under the Plan.

If you choose COBRA Coverage, Gwinnett County Public Schools is required to give you coverage, which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated active employees. The law requires that you be afforded the opportunity to maintain COBRA Coverage for 3 years (36 months) unless you lost coverage or coverage changed because of a termination of employment or reduction in hours. In those cases, the required COBRA Coverage period is 18 months. These 18 months may be extended to 36 months if other events (such as death, divorce, or the employee’s Medicare entitlement) occur during the 18-month period. If the covered employee became entitled to Medicare less than 18 months before a qualifying event, which is termination of employment or reduction of hours, then Qualified Beneficiaries other than the covered employee may receive continuation coverage for up to 36 months measured from the covered

employee's Medicare entitlement. The 18-month coverage period applicable to termination (except for gross misconduct) or to reduction of hours may be extended to up to 29 months if you are determined by the Social Security Administration to have been disabled at any time within the first 60 days of COBRA coverage. In order to extend the 18-month period, you must notify the Plan Administrator by providing a copy of the disability award (within 60 days of a determination by the Social Security Administration and before the end of the 18-month continuation period) of such determination by the Social Security Administration. If you satisfy the above-stated requirements, your coverage may be continued for up to an additional 11 months beyond the end of the initial 18-month period by your electing such additional coverage and paying a higher monthly premium (150% of the applicable premium used to determine regular COBRA rates) for coverage after the end of the initial 18 months. You are also responsible for notifying the Plan Administrator within 30 days after the date of any final determination of the Social Security Administration that you are no longer disabled, if such a determination is made before the 29-month continuation coverage period expires. If you qualify for the 11-month extension, non-disabled family members who are entitled to COBRA continuation coverage will also be entitled to the 11-month extension.

Continuation coverage will be cut short for any of the following five reasons:

1. The Plan is terminated in its entirety;
2. the premium for your continuation coverage is not paid on time, defined initially as within 45 days of the date of the election and thereafter within 30 days of each due date;
3. You become covered under another group health plan which does not contain any exclusion or limitation with respect to any pre-existing condition you have;
4. You become entitled to Medicare; or
5. in the case of the 29-month continuation of coverage period for the disabled, you're ceasing to be disabled.

If COBRA coverage terminates it cannot be reinstated.

You do not have to show that you are insurable to choose COBRA coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage; the Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

Under the law, you may have to pay all or part of the premium, plus a 2% administration fee, for your continuation coverage. As explained above, higher rates apply to the 11-month extension due to disability. There is a grace period of 30 days for payment of the regularly scheduled premium.

Section 7. HIPAA Privacy

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice, which was distributed to you and is available from the Human Resources Department. HIPAA's privacy rules (and all provision of the Plan relating to those privacy rules) were effective beginning April 14, 2003.

This Plan, and the Employer or Plan Sponsor, will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law or the Plan. By law, the Plan has required (or as of the effective date of the HIPAA privacy rules will require) all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, 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 or Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend, the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan maintains a privacy notice, which describes your rights under HIPAA's privacy rules. For a copy of the notice, please contact the Privacy Official or other benefits official of your Plan. If you have any questions about the privacy of your health information, please also contact the Privacy Official. If you want to file a complaint under HIPAA, please contact the Human Resources Department of your Employer.

Section 8. Other Important Information

Funding

Gwinnett County Public Schools and participant contributions fund the benefits and the administration of the Gwinnett County Public Schools Dental Plan. All employee contributions to the Plan shall be withheld from the employee's paycheck on a pre-tax basis.

Name and Type of Plan

The name of this Plan is the Gwinnett County Public Schools Dental Plan.

Plan Administrator

The Plan Administrator is Gwinnett County Public Schools: 437 Old Peachtree Rd, NW, Suwanee, GA 30024-2978; Phone: 678-301-6000. The Plan Administrator has the exclusive power and discretionary authority to interpret the Plan.

Dental Plan Administration

Gwinnett County Public Schools has delegated MetLife to administer all Dental claims for Plan benefits, and has designated MetLife as the Plan's Dental Claims Administrator. The Administrative Service Agreement between Gwinnett County Public Schools and MetLife governs the operation of the Plan at all times.

Expenses for Which Others are Liable

If you or a covered dependent receive Plan benefits for dental care for which another person is liable, this Plan can recover those expenses from the other person or their insurance company, including auto insurance and no fault auto insurance.

Legal Service

Service of legal process concerning the Plan may be made by serving the following: Gwinnett County Public Schools 437 Old Peachtree Road, NW, Suwanee, GA 30024-2978

Plan Records

The Plan and all of its records are kept on a calendar-year basis from January 1 – December 31.

Plan Identification Numbers

The Plan is identified by the following numbers under Internal Revenue Service (IRS) rules:

- Employer Identification Number assigned to Gwinnett County Public Schools by the IRS: 58-6000254

Plan Continuance and Amendment Process

Gwinnett County Public Schools currently intends to continue the Plan for active employees and retirees, under the terms of the Plan, but reserves the right to amend or terminate it at any time with or without notice to participants.

Plan Documents

This booklet is a summary of the Gwinnett County Public Schools Dental Plan and does not attempt to cover all details. Specific details are contained in the Administrative Service Agreement between The Claims Administrator and Gwinnett County Public Schools, which legally governs the operation of the Plan. Plan participants are entitled to examine, without charge, Plan contracts and documents, including the Administrative Service Agreement, the annual report of Plan operations, and such other documents and reports that are maintained by the Plan or filed with a federal government agency.

These contracts and documents are available for review during normal working hours at the Benefits Office. Copies of such contracts and documents will be made available for examination at that work location within 10 days of the date the request was received. At any time, participants may request copies of any Plan contracts and documents by writing to the Plan Administrator. They will be charged a reasonable fee for copies of the contracts and documents requested.

Your Rights as a Plan Participant

It is your right to know as much as possible about your benefits. As a participant in the Gwinnett County Public Schools Dental Plan, you are entitled to certain rights and protections:

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as selected worksites, all Plan documents, including contracts and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

1. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. A reasonable charge may be made for such copies.
2. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

You may continue Plan coverage for yourself, or for your spouse or dependents, if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. You should review this summary plan description and the documents governing your COBRA continuation coverage rights to learn more.