



**GWINNETT
COUNTY
PUBLIC
SCHOOLS**

Summary of Vision Benefits

Vision Benefits for You and Your Dependents

Effective January 1, 2026

Introduction

The Gwinnett County Public Schools Vision Plan, effective January 1, 2026, is designed to provide you vision benefits that you contribute to with tax-free dollars.

This booklet provides the Summary Plan Description (SPD) of the Gwinnett County Public Schools Vision 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, 2026. 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.

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.

Vision Claims Administrator: EyeMed

Gwinnett County Public Schools has contracted with EyeMed for claims administration. You can contact EyeMed at 1-866-723-0514 (Customer Service) or at their website www.eyemed.com to find out specific information regarding claim payments, Explanation of Benefits (EOB), and other data applicable to your benefit.



The following is a summary of the vision benefits for Gwinnett County Public Schools.

COVERED VISION SERVICES – EyeMed Select Plan H

Enrolling and Changing Vision Benefits

New Enrollees – Plan Options

As a new employee you are eligible to enroll in Gwinnett County Public Schools' Vision 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.

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.

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 change your coverage during the next annual enrollment period, your coverage 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 is consistent with the qualifying event.

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

Once an unmarried, incapacitated child’s coverage is in effect, it may continue past the age limitations noted above if your request is made within 31 days before your child’s coverage would otherwise end. To continue coverage, the unmarried child must be mentally or physically incapacitated and Gwinnett County Public Schools must approve the continuation of coverage. It is the employee’s responsibility to send written proof that the child is handicapped and depends on you for most of his/her support and maintenance within 31 days from the date the child reaches the age limit. The employee may be asked for periodic proof that the child’s condition continues. The child’s coverage ends when yours does.

Enrollment

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

- Apply for the coverage using the appropriate procedure; 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 calendar 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:

- a marriage, divorce, or legal separation;
- the birth, legal guardianship, or adoption of a child;
- the death of a dependent;
- 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; and/or,
- 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.

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.

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 single or family levels. They can only elect the coverage they had prior to retirement. If they did not have vision 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 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 other payroll 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

The following is a summary of the vision benefits for Gwinnett County Public Schools.

COVERED VISION SERVICES – EyeMed Select Plan H

I. Examination Benefit

- A. **In-Network Benefit:** A Member is entitled to a paid-in-full comprehensive spectacle eye examination, including dilation, performed by a Participating Provider.
- B. **Out-of-Network Benefit:** A Member is entitled to a comprehensive spectacle eye examination with dilation. The Member must pay at the point-of-service and will be reimbursed 50% of the retail cost up to a maximum allowance of \$300.00 for all out-of-network expenses, after submitting a complete claim.
- C. **Member Pays:** There is no co-payment.
- D. **In-Network Fitting and Follow-up:** Contact lens fit and two follow-ups are available once a comprehensive eye exam has been completed.
 - 1. **Standard Contact Lens:** Spherical clear contact lenses in conventional wear and planned replacement. Examples include, but not limited to, disposable, frequent replacement, etc.
Standard Benefit: Member pays up to \$40 of the usual and customary charge.
 - 2. **Premium Contact Lens:** All lens designs, materials and specialty fittings other than Standard Contact Lenses.
Premium Benefit: A 10% discount off of the usual and customary charge.
- E. **Out of Network, Fitting and Follow-up:** Contact lens fit and two follow-ups are available once a comprehensive eye exam has been completed.
 - 1. **Standard Contact Lens:** The Member must pay at the point-of-service and will be reimbursed 50% of the retail cost for fit and follow-up, up to a maximum allowance of \$300.00 for all out-of-network expenses, after submitting a completed claim.
 - 2. **Premium Contact Lens:** The Member must pay at the point-of-service and will be reimbursed 50% of the retail cost for fit and follow-up, up to a maximum allowance of \$300.00 for all out-of-network expenses, after submitting a completed claim.
- F. **Benefit Frequency:** Once per calendar year.

II. Contact Lens Benefit

- A. **In-Network Benefit:** In lieu of lenses, all Members are entitled to non-disposable, disposable or medically necessary contact lenses for the amounts below. The Member is responsible for the balance over the allowance amount at the time of service.
1. **Non-disposable:** \$150.00 allowance applied toward non-disposable contact lenses. The Member is responsible for 85% of the balance amount over \$150.00 at the time of service.
 2. **Disposable:** \$150.00 allowance applied toward disposable contact lenses. The Member is responsible for 100% of the balance over \$150.00 at the time of service.
 3. **Medically Necessary:** Paid in full benefit toward medically necessary contact lenses.
- B. **Out-of-Network Benefit:** For contact lenses obtained from an out-of-network provider, a Member is entitled to the following:
1. **Non-disposable:** A Member must pay the out-of-network provider at the point-of-service and will be reimbursed 50% of the retail cost up to a maximum allowance of \$300.00 for all out-of-network expenses after submitting a completed claim.
 2. **Disposable:** A Member must pay the out-of-network provider at the point-of-service and will be reimbursed 50% of the retail cost up to a maximum allowance of \$300.00 for all out-of-network expenses after submitting a completed claim.
 3. **Medically Necessary:** A Member must pay the out-of-network provider at the point-of-service and will be reimbursed 50% of the retail cost up to a maximum allowance of \$300.00 for all out-of-network expenses after submitting a completed claim.
- C. **Member Pays:** There is no co-payment.
- D. **Benefit Frequency:** Once per calendar year.

III. Frame Benefit

- A. **In-Network Benefit:** A Member is entitled to a \$150.00 allowance toward a frame with the purchase of prescription lenses. The Member is responsible for 80% of the balance over the \$150.00 at the time of service.
- B. **Out-of-Network Benefit:** A Member must pay the out-of-network provider at the point-of-service and will be reimbursed 50% of the retail cost up to a maximum allowance of \$300.00 for all out-of-network expenses after submitting a completed claim.
- C. **Member Pays:** There is no co-payment.
- D. **Benefit Frequency:** Once per calendar year.

IV. Lens Benefits

- A. **In-Network Benefit:** A Member is entitled to single vision, bifocal, trifocal lenses, and lenticular lenses.
- B. **Member Pays:** There is no co-payment.
- C. **Lens Options:** A Member is entitled to the following lens options for the additional amounts set forth below:
- | | |
|--|--------------|
| Ultra Violet Coating | \$ 0.00 |
| Tint (Solid & Gradient) | \$ 0.00 |
| Standard Scratch Resistant | \$ 0.00 |
| Standard Polycarbonate (<19 years old) | \$ 0.00 |
| Standard Polycarbonate (19 and older) | \$40.00 |
| Standard Progressives (add-on to bifocal)* | \$65.00 |
| Standard Anti-Reflective | \$45.00 |
| Other Add-Ons | 20% discount |
- D. **Out-of-Network Benefit:** A Member must pay the out-of-network provider at the point-of-service and will be reimbursed 50% of the retail cost up to a maximum allowance of \$300.00 for all out-of-network expenses after submitting a completed claim.
- E. **Benefit Frequency:** Once per calendar year.

Note: Discounts do not apply for benefits provided by other group benefit plans. In-network allowances are one-time use benefits, no remaining balance. Out-of-network allowance is a declining balance benefit; member will receive 50% reimbursement of retail costs up to a \$300 allowance per benefit period when a complete claim is filed, applicable to both exam and materials. Lost or broken materials are not covered.

** Standard Progressive Lenses include, but are not limited to the following trade names; Access®, Adaptor®, AF Mini®, Continuous®, Vue®, Freedom®, Sola VIP®, Sola XL® and True Vision®.*

Note: The Benefit provides coverage for medically necessary contact lenses when one of the following conditions exist:

- **Anisometropia** of 3D in meridian powers
- **High Ametropia** exceeding -10D or +10D in meridian powers
- **Keratoconus** when the member's vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses.
- **Vision improvement** other than Keratoconus for members whose vision can be corrected two lines of improvement on the visual acuity chart when compared to the best corrected standard spectacle lenses

The benefit may not be expanded for other eye conditions even if you, or your provider, deem contact lenses necessary for other eye conditions or visual improvement.

V. Laser Vision Benefit

A Member is entitled to a 15% discount or a 5% discount on promotional pricing on LASIK and PRK treatments through the U.S. Laser Network, including pre-operative and post-operative care. However, if the treatment is performed at a LasikPlus Center, which is part of the U.S. Laser Network, and the Member elects to obtain pre-operative and post-operative care not from the LasikPlus Center provider, the other provider may charge additional fees for the pre-operative and post-operative care, which will be the Member's responsibility, and such fees are not subject to the 15% discount or the 5% discount on promotional pricing.

Accessing the Laser Vision Benefit

1. To locate the nearest U.S. Laser Network provider, a Member must call 1-877-5LASER6.
2. After the Member has located a U.S. Laser Network provider, the Member should contact the U.S. Laser Network provider and identify himself or herself as an EyeMed Member. The Member should schedule a consultation with a U.S. Laser Network provider to determine if he or she is a good candidate for laser vision correction.
3. If it is determined that the Member is a good candidate for laser vision correction, the Member should schedule a treatment date with a U.S. Laser Network provider.
4. To activate the benefit, the Member must call the U.S. Laser Network again at 1-877-5LASER6 with his or her scheduled treatment date.
5. At the time the treatment is scheduled, the Member will be responsible to remit an initial refundable deposit to U.S. Laser Network. (If the Member should decide not to have the treatment, the deposit will be returned. Otherwise, the deposit will be applied to the total cost of the treatment.)
6. At the time the Member remits the deposit, U.S. Laser Network will issue to the Member an authorization number confirming the EyeMed discount. This authorization number will be sent to the Member's U.S. Laser Network provider prior to treatment.
7. On the day of the treatment, it is the responsibility of the Member to pay or arrange to pay the balance of the fee.
8. After the treatment, the Member should follow all post-operative instructions carefully. In addition, the Member is responsible to schedule any required follow-up visits with a U.S. Laser Network provider to ensure the best results from the laser vision correction.

VI. Additional Purchases and Out-of-Pocket Discount

Members will receive a 20% discount on remaining balances at Participating EyeMed Providers beyond plan coverage, which may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed's Providers professional services, disposable contact lenses, or services provided by laser providers. Members are also eligible for additional discounts on eyewear purchases. Once the initial benefit has been used, members are eligible for 40% off the retail price of a complete pair eyeglass purchase and 15% off conventional contact lenses.

VII. Limitations and Exclusions

Benefits are not provided for services or materials arising from: orthoptic or vision training; subnormal vision aids, and any associated supplemental testing; medical and/or surgical treatment of the eye, eyes, or supporting structures; corrective eyewear required by an employer as a condition of employment and safety eyewear unless specifically covered under the Plan; services provided as a result of any Worker's Compensation law; plano non-prescription lenses and non-prescription sunglasses (except for the 20% discount); two pair of glasses in lieu of bifocals; aniseikonic lenses; services or materials provided by any other group benefit providing vision care; benefit is not available on certain frame brands in which the manufacturer imposes a no-discount policy.

VIII. SAMPLE SAVINGS

The following examples illustrate how a member's benefit would be applied to the services received at any participating EyeMed provider's office or location:

If a member chooses to receive:

A comprehensive vision care examination:	the member pays \$ 0.00
A frame up to a value of \$150:	the member pays \$ 0.00
One pair of bifocal lenses:	the member pays \$ 0.00
Ultraviolet coating:	the member pays \$ 0.00
The total cost to the member is:	\$0.00

If a member chooses to receive:

A comprehensive vision care examination:	the member pays \$ 0.00
A frame up to a value of \$170:	the member pays \$16.00
A pair of single vision lenses:	the member pays \$ 0.00
Standard anti-reflective coating:	the member pays \$45.00
The total cost to the member is:	\$61.00

The EyeMed network is always growing, and provider locations are subject to change. Therefore, we recommend calling EyeMed's Member Services Department 866-723-0514 or using the Provider Locator service through EyeMed's web site www.eyemed.com to locate the EyeMed Provider closest to you.

Section 5. How to File a Claim

Before you go to a participating EyeMed Provider location for an eye exam, glasses, or contact lenses, it is recommended that you call ahead for an appointment. When you arrive, show the receptionist or sales associate your EyeMed Identification Card, if applicable, or if you should forget to take your card, be sure to say that you are participating in the Gwinnett County Public Schools vision care plan so that eligibility can be verified.

EyeMed Vision Care Customer Service can be reached at 866-723-0514.

When you receive services at a participating EyeMed Provider location, you will not have to file a claim form. At the time services are rendered, you will have to pay the cost of any services or eyewear that exceeds any allowances, and any applicable co-payments. You will also owe state tax, if applicable, and the cost of non-covered expenses (for example, vision perception training).

Time Frames for Processing Claims

Health Claim Processing Activity	Post Service Claims
Plan Initial Determination <ul style="list-style-type: none"> • Initial Review Decision • Extension Period, including extension for Missing Information 	30 calendar days 15 calendar days
Plan Notice of Incomplete Claim <ul style="list-style-type: none"> • Missing Information 	Included in Extension Time above
Claimant Time to Complete Claim <ul style="list-style-type: none"> • Provide Additional Information • Comply with Required Filing Procedure 	45 calendar days 45 calendar days

Time Frames for Responding to Appealed Claims

Activity	Time Frame
Claimant Appeal of Adverse Determination (Denial or Reduction)	180 calendar days
Plan Decision on Appeal	60 calendar days

EyeMed Vision Care has been determined to belong to the post service claims category. If a claim for benefits is denied, EyeMed Vision Care will notify the member in writing of the specific reasons for the denial. The member may request a full review by EyeMed Vision Care within 180 days of the date of a denial. The member's written letter of appeal should include the following:

- The applicable claim number or a copy of the EyeMed Vision Care denial information or Explanation of Benefits, if applicable.
- The item of your vision coverage that the member feels was misinterpreted or inaccurately applied.

- Additional information from the member's eye care provider that will assist EyeMed Vision Care in completing its review of the member's appeal, such as documents, records, questions or comments.

The appeal should be mailed to the following address:

EyeMed Vision Care, L.L.C.
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, Ohio 45040

EyeMed Vision Care will review your appeal for benefits and notify you in writing of its decision, as well as the reasons for the decision, with reference to specific plan provisions.

Member Grievance Procedure

If the member is dissatisfied with the services provided by an EyeMed Vision Care Provider, the member should either write to EyeMed at the address indicated above or call the EyeMed Vision Care Member Services toll free telephone number at 866-723-0514. The EyeMed Vision Care Member Services representative will log the telephone call and attempt to reach a resolution to the issues raised by the member. If a resolution cannot be reached during the telephone call, the EyeMed Vision Care Member Services representative will document all of the issues or questions raised. EyeMed Vision Care will use its best efforts to communicate back with the member within four (4) business days with a decision or resolution to the issues or questions raised. If the member is not satisfied with the resolution, the member may file a formal appeal as set forth above related to a denial of benefits.

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.

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.

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 Vision 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 GCPS privacy notice, which is available from the Human Resources Department, or online at www.gwinnett.k12.ga.us/benefits. 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 GCPS Division of Human Resources.