SUMMARY PLAN DESCRIPTION

OF THE GWINNETT COUNTY HEALTH BENEFIT PLAN

Gwinnett

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NOTICE

This document, which is called the Summary Plan Document (SPD), describes the benefits under the Gwinnett County Benefits Plan (hereinafter referred to as the Plan) as established for eligible employees, retirees, COBRA participants (and their eligible dependents) of Gwinnett County Board of Commissioners (hereinafter referred to as the Employer or Sponsor). A thorough understanding of the coverage and health benefits under the Plan will enable the employees and retirees to use their benefits most effectively.

The Sponsor hereby established the Plan based on the terms and conditions in this SPD and the incorporated documents. The incorporated documents are listed in the Active Benefits Book and the Retiree Benefits Book. You can access these Books at any time through GC Workplace, or by contacting the Plan Administrator at Benefits@GwinnettCounty.com or 770.822.7915.

You will also have access to this SPD and all Benefits Books when you are initially eligible to enroll in the Plan and again during the annual enrollment periods. This SPD is a wrap document and includes the following benefit documents for the Plan:

- Medical Plans
  - High Deductible Health Plan
  - Traditional PPO Plan (Retirees Only)
  - HMO Plan
  - Medicare Advantage Plan
- Dental Plans
  - Dental HMO (DHMO) Plan
  - Mid Option Dental
  - High Option Dental
- Vision Plans
  - Basic Vision Plan
  - Premier Vision Plan
- Spending Accounts
  - Health Savings Account (HSA)
  - Health Reimbursement Arrangement (HRA)
  - Health Care Flexible Spending Account (FSA)
  - Dependent Care Flexible Spending Account (FSA)
- Life Insurance
  - Basic Life Insurance
  - Employee Optional Life Insurance
  - Spouse Optional Life Insurance
  - Child Optional Life Insurance
- Disability Plans
  - Short-Term Disability Insurance Plan
  - Long-Term Disability Insurance Plan

- Supplemental Insurance Plans
  - Accident Insurance Plan
  - Critical Illness Insurance Plan
  - Hospital Indemnity Insurance Plan
- Maven Wallet Reimbursement Plan
- Gwinnett County Wellness Program

This SPD also includes enrollment materials and other general communications identified as containing information about benefits under the Plan, as well as pertinent contracts between the Sponsor and the claims administrators that provide services under the Plan.

These documents are incorporated into this SPD and serve as the source of specific information relating to the Plan. This SPD and the incorporated documents function as one document to summarize the Plan.

The SPD is intended to provide an easy-to-read explanation of the Plan, but it does not guarantee benefits. Every effort has been made to make this information as accurate as possible. If there is any conflict between this SPD and the incorporated documents, the incorporated documents will govern in all cases. No rights or benefits will be gained because of misstatements in, or omissions from this SPD.

Participation in the Plan does not guarantee continued employment with the Employer, nor does it altar at-will employment status. If an employee quits, is discharged or laid off, the Plan does not provide health benefits or interest, except as specifically provided in the incorporated documents and under the *Consolidated Omnibus Budget Reconciliation Act of 1985,* as amended (COBRA).

The Sponsor reserves the right to revise the Plan and the benefits provided to employees, retirees, and dependents at any time and also reserves the right to change the participant contributions for coverage under the Plan.

This SPD is effective January 1, 2024 and replaces any previous SPD for the Plan.

CAFETERIA PLAN BENEFITS

The Sponsor's benefit program is considered a cafeteria plan that qualifies under Internal Revenue Code (IRC) Section 125. This allows the employee to pay the premium contributions for these health benefits, when applicable, on a pre-tax basis. It also requires that the Employer adhere to IRC Section 125 regulations concerning such terms as when any changes are made to elections each year.

YOUR HEALTH BENEFITS & TERMS OF COVERAGE

Eligible employees of the Employer and their dependents are eligible for the following health benefits under the Plan:

- Medical Benefits, including prescription drug benefits.
- Dental Benefits
- Vision Benefits
- Health Savings Account (for those on a high deductible health plan)
- Health Reimbursement Account (for those on an HMO plan)
- Flexible Spending Accounts (restrictions apply)
- Disability Insurance
- Life Insurance
- Accident, Hospital Indemnity, and Critical Illness Insurance
- Maven Wallet Reimbursement Program
- Wellness Program, including a premium discount and a tobacco surcharge.

Eligible retirees of the Employer and their dependents are eligible for the following health benefits under the Plan:

- Retiree Medical Benefits, including prescription drug benefits.
- Dental Benefits
- Vision Benefits

The details of each of these health benefits are described in the incorporated documents.

TERMS OF COVERAGE
The Plan provides the benefits described in this SPD only for eligible participants.

Benefit payments for covered health services or supplies will be made directly to preferred, participating, or contracted providers. Payment will be made to you for covered health services or supplies from a non-preferred, non-participating, or non-contracted provider.

The Plan does not supply or recommend hospitals or physicians. Neither the Plan nor the Plan Administrator nor the claims administrators are responsible for any injuries or damages you may suffer due to actions of any hospital, physician, or other person.

In order to process claims, the claims administrators may request additional information about the medical treatment received and/or other group health coverage which you may have. This information will be treated confidentially.

An oral verification of benefits by a claims administrator's employee is not legally binding.

Any correspondence mailed to you will be sent to the most current address on file. You are responsible for notifying the Plan Administrator by contacting Human Resources or by changing your address in the HRIS system through *MyGCHub* when you have a change in address.

OUTCOME OF COVERED SERVICES AND SUPPLIES
The Employer is not responsible for, and makes no guarantees concerning, the outcome of the covered services or supplies for which you receive payments under the Plan.

You are solely responsible for your choice of health care providers, services, and/or supplies. Obtaining health care and determining which provider, service, and/or supply to use shall not be construed, interpreted, or deemed as resulting from the Plan or any incorporated document.

You must make a decision as to your health care independent of any determinations to whether payment will or will not be made under the Plan for that health care. The determination of whether or not health care is medically necessary is made solely for purposes of determining whether payments for benefits will be made under the Plan and is not intended to be advice to you about your health care.

COST OF COVERAGE
You pay a portion or all of the cost of coverage and benefits, depending on the coverage or benefit, for you and your dependents under the Plan, and the Employer pays the remainder. Employees pay participant contributions by pre-tax payroll deductions. Retirees pay participant contributions on an after-tax basis, as billed. Note that the full cost of dental and vision benefits is paid by the participant.

The Plan Administrator determines the amount of participant contributions prior to each enrollment period and will provide this information to you with the enrollment materials. You may also contact the Plan Administrator to receive information about participant contributions.
Note that the cost of health coverage does not include your payments for any applicable deductibles, co-pays, coinsurance, out-of-network charges, or non-covered items.

FUNDING AND SOURCE OF CONTRIBUTIONS
The Plan is funded by participant pre-tax contributions, participant after-tax contributions, and Employer contributions. Health benefits other than insured benefits are paid from the general assets of the Employer; insured benefits are paid by the insurance companies who have entered into contracts with the Sponsor to provide those insured benefits.

Premiums for the COBRA continuation of health benefits are paid for by COBRA participants on an after-tax basis.

Any refund, rebate, dividend, experience adjustment, or other similar payment under an insurance contract will be applied first to reimburse the Employer for its contributions, unless otherwise provided in that insurance contract or required by applicable law.

PARTICIPATING PROVIDER NETWORKS AND DIRECTORIES
For health benefits provided through a network, you may obtain the participating provider directories from the claims administrator for a particular benefit, free of charge.

Newborns' and Mothers' Health Protection Act of 1996
The Newborns' and Mothers' Health Protection Act requires plans that offer maternity coverage to pay for at least a 48-hour hospital stay following childbirth (96-hour stay in the case of a cesarean section). Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any length of hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarian section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain an authorization from the plans or the insurance issuers for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998
The Women's Health and Cancer Rights Act requires the Plan to cover the following services:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of any physical complications resulting from the mastectomy, including lymphedemas.

The law prohibits the Plan from:

- Denying a participant or a beneficiary eligibility to enroll or renew coverage under the Plan in order to avoid the requirements of the law.
- Penalizing, reducing, or limiting reimbursement to the attending provider (e.g., physician, clinic, or hospital) to induce the provider to provide care inconsistent with the law.
- Providing monetary or other incentives to an attending provider to induce the provider to provide care inconsistent with the law.

Health benefits for the above services are subject to the same general provisions that apply to other services covered under the Plan, for example:

- Contracted vs. non-contracted providers; in-network and out-of-network providers, and referrals/authorizations. The coverage may be subject to annual deductible and coinsurance provisions.

Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008
The Mental Health Parity and Addiction Equity Act states, that with some exceptions, a group health plan that provides mental health and/or substance abuse benefits may not place special limitations on benefits related to mental health treatment or substance use disorders.

The MHPAEA states that:

- Treatment limits, such as number of days or services allowable, cannot be more restrictive than the most common or frequent limitations applied to medical and surgical benefits provided by the Plan.
- Cost-sharing features of the Plan, including deductibles, co-pays, coinsurance, and out-of-pocket expenses, cannot be more restrictive regarding mental health and/or substance abuse benefits than the most common or frequent cost-sharing features applied to medical and surgical benefits provided by the Plan.
- If the Plan offers out-of-network benefits for medical and surgical services, out-of-network benefits must also be offered for mental health and/or substance abuse disorders. The Plan offered by the Sponsor complies with the terms of the MHPAEA.

Genetic Information Nondiscrimination Act (GINA) of 2008

The Genetic Information Nondiscrimination Act prohibits discrimination on the basis of genetic information. The law states that it is illegal for group health plans and health insurers to deny coverage or charge higher insurance premiums or contribution rates to an individual found to have a genetic predisposition toward a disease or disorder. The law also makes it illegal for employers to consider an employee's genetic information when making hiring, firing, placement, or promotion decisions.

GINA prohibits:

- Access to individual genetic information by plans and insurance companies making enrollment decisions and employers making hiring decisions.
- Plans and insurance companies from discriminating against an applicant for health insurance based on genetic information, the refusal to produce genetic information, and/or for having been genetically tested in the past.
- Plans and insurance companies or employers from requesting that applicants for health insurance benefits be genetically tested.
- Employers from collecting genetic information.

• Genetic information cannot be requested, required, or purchased for underwriting purposes or to be used in determining eligibility for enrollment in the Plan. Genetic information cannot be used to adjust premiums or to determine Employer contributions for health benefits.

The Plan is allowed to request and use genetic testing results when the information is necessary to make claim payment determinations. When that is the case, only the minimum necessary information can be requested and/or used by the Plan.

HEALTH CARE REFORM

The Plan shall comply with the coverage and medical benefit provisions required by the Patient Protection and Affordable Care Act of 2010 as amended by the Health Care and Education Reconciliation Act of 2010 (the "ACA").

RIGHT OF RECOVERY OR SUBROGATION
If you or your dependents have claims for damages or a right to reimbursement from a third party for any condition, illness, or injury for which benefits are paid by the Plan, the Plan has a right to recovery.

The Plan's right to recovery is limited to the amount of benefits paid by the Plan for covered medical expenses. It does not include non-medical items. Money received for future medical care or pain and suffering is not recoverable by the Plan under this provision. The Plan's right of recovery will include compromised settlements. You or your representative must inform the Plan Administrator of any legal action or settlement discussions no later than 10 days prior to settlement or beginning of a relevant trial. The Plan Administrator will then notify you of the amount it seeks to recover.

FRAUDULENT STATEMENTS
Fraudulent statements on your application or enrollment will invalidate any payment or claims for benefits and be grounds for voiding your coverage. Fraudulent statements on your application or enrollment could also be grounds for other disciplinary action, up to and including termination of employment from the Employer.

Note, however, that any retroactive cancellation of health coverage subject to the ACA will comply with the ACA's limitations and requirements for recession of coverage.

CHANGES IN COVERAGE, BENEFITS, AND/OR PARTICIPANT CONTRIBUTIONS
The Plan Administrator and the claims administrators may mutually agree to change the benefits described in this SPD. Furthermore, the Plan Administrator reserves the right to change or eliminate plans and claims administrators, change the type or level of benefit coverage, and adjust the contributions or percentages paid by employees, retirees, disabled employees, and COBRA participants. The Plan Administrator also reserves the right to add to or eliminate the type of participants eligible for coverage under the Plan.

RELIEF FROM RESPONSIBILITIES
The Employer, the Plan administrator, and the claims administrators are relieved of their responsibilities without breach if their duties become impossible to perform by acts of God, war, terrorism, fire, etc. The claims administrators will adhere to the Employer's instructions and allow the Employer to meet all of the Employer's responsibilities under applicable state and federal law.

ACTS BEYOND REASONABLE CONTROL (FORCE MAJEURE)
Should the performance of any act required by this SPD be prevented or delayed by reason of any act of God, strike, lock-out, labor troubles, restrictive government laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and nonperformance of the act during the period of delay will be excused. In such an event; however, all parties shall use reasonable efforts to perform their respective obligations.

ELIGIBILITY & ENROLLMENT

MEDICAL LEVELS OF COVERAGE – ACTIVE EMPLOYEES

- Employee Only – No dependent coverage
- Employee + Spouse –No dependent children
- Employee + Child(ren)—Employee + one or more children, no spouse
- Family—Employee, spouse, and one or more children

MEDICAL LEVELS OF COVERAGE – RETIREES

- Retiree Only—No dependent coverage
- Retiree + Spouse—No dependent children
- Retiree + Child(ren)—Retiree + one or more children, no spouse
- Family—Retiree, spouse and one or more children
- Surviving Spouse—Surviving spouses of retirees and ex-elected officials

Note: Please see the OPEB Policy for details on coverage for dependents of retirees.

YOUR COVERAGE

This SPD describes the health benefits that eligible employees may receive under the Plan. When an eligible employee enrolls in and begins participating in the Plan, the employee is also called a participant. You are an eligible employee if you are:

- Working for the Employer on a permanent full-time basis
- Working for the Employer on a permanent part-time basis and credited with at least 30 hours of service per week.
- Working for the Employer as a limited-term full-time employee
- An elected official

You are also eligible to participate in the Plan if you retire from the Employer, are eligible for retiree health benefits, and elect to continue coverage at retiree rates.

The following individuals are not eligible employees:

- Leased employees
- Independent contractors or those covered under individual employment contracts, unless the contract or agreement specifies that the individual is eligible to participate.

If you are excluded from the Employer's definition of an eligible employee, you will not be eligible for benefits under the Plan, even if a court, the Internal Revenue Service (IRS), or any other enforcement authority finds that you should be considered an eligible employee.

If you become disabled while employed by the Employer, you are eligible to continue health benefits for a maximum of two (2) years. Benefits can continue past two (2) years if your disability is total and permanent, as defined by the Social Security Administration, and if you are receiving approved disability benefits provided by the Employer.

The Plan Administrator will verify all employee and retiree eligibility.

YOUR ELIGIBILITY FOR ACTIVE MEDICAL BENEFITS UNDER THE ACA
Eligibility for active medical benefits under the Plan will be determined in accordance with the employer shared responsibility provisions of the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (the "ACA").
For purposes of the ACA's employer shared responsibility provisions (under Code Section 4980H), your hours of service for active medical benefits will be credited using the look-back measurement method. Under this measurement method, you will have your hours of service measured during the Measurement Periods to determine your eligibility for medical benefits during the associated Stability Periods. You are eligible for the active medical benefits under the Plan, if:

You are expected to be a full-time employee when hired, or

- You are determined by the Employer not to be a full-time employee as of your date of hire, but are credited with an average of at least 30 hours of service per week during your Initial Measurement Period, or
- You are credited with an average of at least 30 hours of service per week during the Standard Measurement Period

Full-time means that you are reasonably expected by the Employer to be credited with an average of at least 30 hours of service per week. Employees that are hired into full-time positions will generally be eligible to enroll in medical benefits effective as of the first day of the calendar month following one full calendar month of employment. Until the employee has been employed for an entire Standard Measurement Period, his medical coverage continues, based on his being hired as a full-time employee. After a full-time employee has been employed with the Employer for an entire Standard Measurement Period, the employee's eligibility for medical benefits for each subsequent Standard Stability Period will be conditioned on the employee remaining employed with the Employer and being credited with an average of at least 30 hours of service per week during each Standard Measurement Period associated with that Standard Stability Period.

Hour of service means each hour for which you are paid, or entitled to be paid, by the Employer for the performance of duties for the Employer and each hour for which you are paid, or entitled to be paid, by the Employer for a period of time during which you perform no duties for the Employer due to vacations, holidays, illness, incapacity, layoff, jury duty, military duty, or leaves of absence.

Standard Measurement Period	October 4 through October 3 each year
Standard Stability Period	January 1 through December 31 each year. This is the year of the plan.
Initial Measurement Period	The 12-month period beginning on the first day of the calendar month coincident with or next following your date of hire.
Initial Stability Period	The 12-month period beginning on the first day of the second calendar month following the month in which your first anniversary of employment begins.

If you are a newly-hired employee and the Employer does not reasonably know if you will be credited with an average of at least 30 hours per week, here is an example of how your hours of service will initially be measured:

- You are hired on May 2, 2015. Your Initial Measurement Period will run from June 1, 2015 through May 31, 2016. Your Initial Stability Period will run from July 1, 2016 through June 30, 2017. In addition, you will be measured during the Standard Measurement Period that runs from October 4, 2015 through October 3, 2016.

Please note that special rules apply if you are a re-hired employee, have a break in service, take a leave of absence, or change your job classification. For questions regarding eligibility for coverage under the Plan, contact the Plan Administrator.

COVERAGE FOR EMPLOYEES WHO CHANGE FROM PART-TIME TO FULL-TIME

If your employment status changes from part-time (working less than 30 hours per week) to full-time, you will be eligible for benefits on the effective date of your status change. If you elect benefits, coverage will be effective the first of the month after you have been in this status for one calendar month.

COVERAGE FOR EMPLOYEES WHO ARE REHIRED

If you terminate employment and are rehired by the Employer during the same plan year and within 30 days of your prior termination of employment, you will continue to be eligible for the same pre-tax Plan elections in which you participated prior to your termination of employment.

If you are rehired more than 30 calendar days after your prior termination of employment or during a subsequent plan year, you must enroll again in the Plan to receive pre-tax benefits.

COVERAGE FOR YOUR DEPENDENTS

If you enroll for coverage under the Plan, your eligible dependents may also be enrolled in the Plan. Enrolled dependents are also called participants. The Plan Administrator will verify all dependent eligibility.

For purpose of the Plan, eligible dependents include your:

- Spouse. Note that an individual is not your spouse if:
  - You and the individual are legally separated, divorced, or have obtained an annulment.
  - The individual is considered a spouse by common law (unless grandfathered by the Employer prior to January 1, 1997)
- Children, until attaining age 26. This includes biological children, stepchildren, legally adopted.
  children (from the date you assume documented legal responsibility), and children for whom you have legal guardianship.
- Children who are mentally or physically disabled and totally dependent upon you for support, regardless of age, provided that the disability began prior to age 26. Documentation necessary to certify the disability will be determined by the Plan Administrator. You must contact the Plan Administrator and provide the required documentation within 30 days of the child attaining age 26.

- Children for whom health coverage is required though a qualified medical child support order ("QMCSO")

ENROLLMENT IN THE PLAN
You may enroll in the Plan using the enrollment procedures established by the Plan Administrator. The Plan Administrator will notify you about the enrollment procedures prior to each enrollment period.

Newly-hired employees must enroll in the Plan within 30 calendar days of their date of hire. Coverage will be effective on the first day of the calendar month following one full calendar month of employment. If you intend to waive coverage for any or all of the offered benefits, you must still complete enrollment, indicating that you are waiving benefits. If you do not enroll when first eligible, you will not be able to enroll until the next annual enrollment period, unless a Life Status Change occurs. See Life Status Change for details.

Every year, the Plan Administrator will designate an annual enrollment period during which you may elect benefits under the Plan for the following plan year if you were not previously enrolled in the Plan or during which you may change your benefit elections if you were previously enrolled in the Plan. Note however, new elections must be made during each annual enrollment period for FSA contributions for the next plan year. Coverage will be effective on the first day of January of the following plan year. If you intend to waive coverage for any or all of the offered benefits, you must still complete enrollment, indicating that you are waiving benefits. If you do not make an election during the annual enrollment period, you will not be able to enroll until the next annual enrollment period, unless a Life Status Change occurs. See Life Status Change for details.

For other qualifying events (divorce or legal separation or a dependent child losing eligibility for coverage as a dependent child) or the occurrence of a second qualifying event, you or the qualified beneficiary must notify the Plan Administrator within 60 days after the date the qualifying event occurs or the day the qualified beneficiary loses coverage because of the qualifying event. If you or the qualified beneficiary fails to notify the Plan Administrator within this 60-day period, the dependent will not be entitled to elect COBRA continuation coverage. In addition, if any benefit claims are mistakenly paid for expenses incurred after the date health benefit coverage under the Plan would normally be lost because of the qualifying event, you will be required to reimburse the Plan for any payments mistakenly made.

DOCUMENTATION FOR YOUR DEPENDENTS
You are required to substantiate the eligibility of your dependents who are enrolled in the Plan. If documentation is not submitted and validated for your dependents, you will have Employee Only coverage as of your effective date.

The following is a list of documentation required for each dependent (spouse or child):

- Spouse documentation: Two (2) forms of documentation are required to enroll a spouse for coverage
  - A photocopy of a certified marriage certificate

AND One of the following:

- Current joint mortgage or rental contract or statement with both you and your spouse's name
- Current joint bank account statement showing both you and your spouse's name at the same mailing address.
- Current joint credit card statement showing both you and your spouse's name at the same mailing address.
- Most recent year's signed federal income tax return (without supporting schedules and attachments), with both you and your spouse's name.

Please contact the Plan Administrator if you do not have any of the listed documents. Before sending one of these documents to the Plan Administrator, you should block out (or otherwise remove) any information that is not necessary for the purpose of verifying eligibility, including dollar amounts, Social Security Numbers, and account numbers. Note: "current" means dated within the last six (6) months.

- Dependent Child documentation: A copy of only one of the following documents with your name and/or that of your spouse as the parent is required:
  - Copy of certified birth certificate
  - Legal Guardianship/Custody: Final Decree with presiding judge's signature and seal
  - Final Adoption Decree with presiding judge's signature and seal

- For newly-adopted children, the effective date of coverage will be the earlier of the following events:
  - The date of legal placement for adoption, during which you have been determined legally responsible for providing the child's health coverage.
  - The Final Adoption Decree with the presiding judge's signature and seal

Regardless of which date applies, the child must be enrolled within 30 days of that date in order for coverage to be effective.

- Documentation of disabled child status (age 26 and older): In addition to the documentation required to cover a dependent child, for a disabled child who is over the age of 26, one of the following must be submitted:
  - Photocopy of the Social Security disability award, or
  - If a disability ruling by the Social Security Administration is pending, a copy of the application for disability.

ALTERNATE DEPENDENT DOCUMENTATION
Valid copies of the documentation listed above will be adequate. However, if any of the above documentation is not available in a timely fashion (e.g., in the event of a birth or marriage abroad), consideration will be given to other forms of documentation when accompanied by a signed letter from you explaining why the requested documentation is not readily available. Alternate documents must be from third-party organizations, such as governments, businesses, or religious organizations. The documents must indicate that the marital or parental relationship exists. Examples include hospital records, church records, school records, immigration records, contracts, etc. Contact the Plan Administrator for assistance.

STATE REQUIRED DOCUMENTATION
To be eligible for coverage under the Plan, you and your dependents who are 18 years of age or older must complete and submit an "Affidavit Verifying Eligibility Status of Public Benefit Applicant" form to the Benefits Office of the Department of Human Resources. This is pursuant to the Georgia Security and Immigration Act of 2006, which requires every agency administering or providing public benefits to be responsible for determining U.S. citizenship or lawful alien status. You may contact the Benefits Office for a copy of this form.

PROCEDURES FOR SUBMISSION OF DEPENDENT DOCUMENTATION
Upon final completion of the enrollment process, you should print and review a confirmation statement to assure accuracy of your enrollment. You may then attach copies of required dependent documentation to a copy of the confirmation statement and send it to the Benefits Office of the Department of Human Resources. Clear copies of the documents will be adequate. Documents will not be returned. Documents must be received in the Benefits Office within 30 days of hire or the date the benefits will become effective for you and your dependents.

Upon receipt, documents will be reviewed within five (5) business days by designated Department of Human Resources staff. If the documentation is deemed adequate, no further action is necessary. When your dependents have been validated, the documentation will not be retained.

If the documentation is deemed inadequate, Department of Human Resources staff will request additional documentation or clarification from you. If the documentation leads to the conclusion that a dependent is ineligible, the staff will request authorization from the Benefits/Retirement Plan Manager to deny enrollment of the dependent. Immediately upon denial of eligibility of any dependent, the staff will mail a letter to your home address, explaining the reasons for the denial and offering a 30-day opportunity for you to appeal by submitting specified additional documentation.

All coverage for dependents ruled ineligible will be suspended until an appeal is processed and approved. Documentation for invalidated dependent(s) will be retained.

You may appeal the eligibility denial by filing the acceptable additional documentation within 30 days of the date of the denial letter. If the Department of Human Resources staff determines that the dependent eligibility cannot be validated, there will be an automatic appeal to the Benefits/Retirement Plan Manager. If the Benefits/Retirement Plan Manager upholds the denial, you may file a final appeal, in writing, to the Director of Human Resources within 60 calendar days of the date of the denial letter sent

via certified mail. The letter must clearly explain any extenuating circumstances that result in your inability to provide adequate documentation, and any available documentation not yet provided should be attached. Upon review of the entire file, the Director of Human Resources will make a final ruling or may issue an extension of time for you to obtain complete documentation.

If the appeal is approved, coverage for the dependent will be effective retroactive to the date of your coverage. Associated participant contributions will be collected from you through payroll deductions.

LIFE STATUS CHANGE

Except for during the annual open enrollment process, you are not able to add or delete coverage for yourself or your dependents. However, you can make changes to your election during the plan year if:

- You experience a Life Status Change, have a special enrollment right, or experience another change in circumstances.
- That event or other change affects the eligibility for benefits under the Plan for either you or your dependents, as determined by the Plan Administrator.
- The modification in your election is due to and consistent with the event or other change, as determined by the Plan Administrator.

A Life Status Change is one of the following situations that occurs mid-plan year:

- Change in legal marital status, including marriage, death of your spouse, divorce, legal separation, or annulment.
  - In the case of divorce, the former spouse is no longer an eligible dependent under the Gwinnett County health plan. For purposes of employee benefits, where there is a covered spouse, the notice of divorce must be reported to Human Resources within 30 days of the event. Failure to remove divorced spouse from coverage within 30 days of the divorce event will result in the employee reimbursing Gwinnett County to recover any employer premium paid for the total number of months the divorced spouse remained covered on the Plan. The employee may also be subject to disciplinary action, up to and including termination.

- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent. This includes a dependent who becomes an eligible employee of the Employer.
- Change in employment status, including termination or commencement of employment of you, your spouse, or other dependent.
- Changes in work schedule, including an increase or decrease in the number of hours of employment by you, your spouse, or other dependent (including a transition from full-time or part-time status, a strike or lockout, or commencement or return from an unpaid leave of absence)
- Your dependent satisfies or ceases to satisfy the requirements/definition of a covered dependent, as required by the Plan through which you are covered, by any means such as attainment of age or similar circumstances.
- A change in the place of residence or work site of you, your spouse, or other dependent that affects eligibility for health benefits.

- A Qualified Medical Child Support Order (QMCSO) requiring you to cover your dependent child becomes effective or expires.
- Enrollment in or loss of eligibility for Medicare or Medicaid
- Eligibility for premium assistance, with respect to coverage under the Plan, or loss of coverage under Medicaid or an S-CHIP plan. You must enroll yourself and/or your dependent for coverage within:
  - 60 calendar days of when coverage under Medicaid or an S-CHIP plan ends
  - 60 calendar days of the date you or your dependent becomes eligible for Medicaid or S-CHIP premium assistance
- Change in Cost. If you are notified that the cost of coverage under the Plan significantly increases or decreases during the plan year, you may make a corresponding change in your elections under the Plan. You may commence participation in Plan option with a decrease in cost; or, in the case of an increase in cost, you may choose to: (1) make an increase in contributions; or (2) revoke coverage and elect another Plan option that provides similar coverage; or (3) drop Plan coverage if there is no other Plan option that provides coverage similar to the existing coverage (This "Change in Coverage" exception is not applicable to the Health Care Flexible Spending Account under the Plan.)
- Change in Coverage. If the Plan Administrator notifies you that your coverage under the Plan is significantly curtailed (e.g., a provider network ceases to be available to you), you may revoke your election and elect coverage under another Plan option that provides similar coverage. If, during the plan year, the Plan eliminates a coverage option, you may revoke coverage and elect another Plan option that provides similar coverage or drop Plan coverage if there is no other Plan option that provides coverage similar to the existing coverage. If the Plan adds a new Plan option, or if coverage under an existing Plan option is significantly improved during a plan year, you may elect the newly-added Plan option or the improved Plan option, whether or not you previously made an election under the Plan, and may do so on a pre-tax basis (This "Change in Coverage" exception is not applicable to the Health Care Flexible Spending Account under the Plan.)
- Change in Coverage Under Another Employer Plan. You may make a change that is due to, and corresponds with, a change to your spouse's or other dependent's employer plan, as long as: (a) that employer's plan permits its participants to make a change permitted under the IRS regulations; or (b) the Plan permits you to make an election for a period of coverage which is different from the period of coverage under your spouse's or other dependent's employer plan(This "Change in Coverage" exception is not applicable to the Health Care Flexible Spending Account under the Plan.)
- Loss of Other Coverage. You may elect to add coverage under the Plan for you, your spouse, or your other dependents if any of you loses coverage under any group health coverage sponsored by a governmental or educational institution, including the following: (1) a state's children's health insurance program (SCHIP) under Title XXI of the Social Security Act; (2) a medical care program of an Indian Tribal government (defined in Code Section 7701(a)(40)), the Indian Health Service, or a tribal organization; (3) a state health benefits risk pool; or (4) a foreign government group health plan (This "Change in Coverage" exception is not applicable to the Health Care Flexible Spending Account under the Plan.)

The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), gives you additional flexibility in whom you can enroll for the benefits under the Plan due to marriage, birth, adoption, or placement for adoption:

- Non-enrolled employee: If eligible but not enrolled, you can enroll as of the date of the event.
- Non-enrolled spouse: If you are enrolled, you can enroll your spouse upon marriage. In addition, you can enroll your spouse if you acquire a child through birth, adoption, or placement for adoption. If you are not enrolled, you must also enroll.
- Non-enrolled dependents: You can enroll your dependent children as the result of an event. However, if you are not enrolled, you must also enroll.

In addition, HIPAA provides you with special enrollment rights in the event of the following events:

- You elected "no coverage" under this Plan because you had health coverage elsewhere (for example, under a spouse's plan) and that other health coverage ends later
  - The other health coverage must end because of a loss of eligibility, such as a divorce; termination of employment; the other employer stops offering its plan to the eligible class to which you belong; the other employer stops contributing to its plan; or you or your dependent(s) no longer reside, live, or work in the other plan's network service area and no other health coverage is available under the other plan
  - You cannot make an election change during the plan year if your other health coverage is lost because of something you do or do not do, such as not making your required contributions.
- Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") continuation coverage from another employer for you or your dependent is exhausted.

The Plan Administrator must be notified, in writing, within 30 calendar days of the Life Status Change in order for the change to be effective. If approved, the change in benefits and/or coverage will be effective the day of the event.

MEDICAL CHILD SUPPORT ORDERS ("MCSO") OR NATIONAL MEDICAL SUPPORT NOTICES ("NMSN")

A MCSO is a judgment from a state court or an order issued through an administrative process under state law that requires a parent to provide health benefits for a child (often because of legal separation or divorce). An NMSN is an exclusive document that state child support enforcement agencies are required to use when enforcing the health coverage provisions of medical child support orders. Neither of these orders can require the Plan to cover any type or form of benefit not otherwise offered. However, an order may require the Plan to comply with state laws regarding a child's health coverage.

An order may require health coverage under the Plan for your child even if you are divorced, your ex-spouse has legal custody of your child, and your child is not dependent on you for support. The order also gives you a special enrollment right to add coverage outside of any annual open enrollment period restrictions.

If the Employer receives a valid order, you may enroll your dependent child for health benefits under the Plan pursuant to the order's terms. The change you elect takes effect as of the date the order is processed. If the Employer receives a valid order and you do not enroll your dependent child for health benefits under the Plan pursuant to the order's terms, the Plan will provide health benefits for your child in accordance with the terms of the order. The cost of coverage provided pursuant to the order will be automatically withheld from your pay, subject to any limits set by state or federal law.

Note that, if you are not enrolled in the Plan, you must also enroll when your dependent child is enrolled under a valid order.

Federal law requires that a MCSO must meet certain form and content requirements to be valid. When processing and administering benefits under an NMSN, the Plan Administrator must also comply with the law's general MCSO requirements. Thus, the Employer follows certain procedures to determine if a MCSO or a NMSN is valid. You may request, without charge, a copy of the Plan's administrative procedures for processing orders from the Plan Administrator. If you become subject to an order, you will receive a copy of these administrative procedures, free of charge, from the Plan Administrator.

TERMINATION OF COVERAGE

You may continue to participate in the Plan as long as you meet the Plan's eligibility requirements. Participation ceases if your employment ends or if you fail to make any required participant contribution. In either instance, coverage will end on the last day of the calendar month in which the termination occurred or at the end of the period covered by your last participant contribution. In addition:

- Coverage of your enrolled child ceases at the end of the month in which your child attains age 26.
- Coverage of your disabled child over age 26 ceases if your child is found to be no longer totally or permanently disabled.
- Coverage of your spouse will end the last day of the month in the month in which you and your spouse are divorced.

If you or your dependent is receiving covered care in the hospital at the time participation terminates for reasons other than your cancellation of the Plan or failure to pay the required participant contributions, benefits for hospital inpatient care will be provided only to the extent available for that hospital stay.

COORDINATION OF BENEFITS

Health benefits under the Plan will be coordinated with other group plans covering you and your dependents.

If you are covered under another group health care plan (as the primary plan), health benefits under the Plan will be coordinated with any benefits payable under that other plan so that no more than 100 percent of the total billed or allowable charges will be paid. Payment under the Plan will be reduced by payments made under the other plan, but the Plan will pay up to 100 percent of the allowable amount.

Coordination examples:

- Your spouse is covered under her employer's health care plan. Her plan has an office visit co-pay of $25. If the plans also have an office visit co-pay of $25, the plans would pay nothing.
- Your spouse is covered under her employer's health care plan. Her plan has an inpatient co-pay of $500, balance paid at 100 percent. If the Plan has an inpatient co-pay of $200, this Plan would pay $300.

It is your obligation to supply requested information for all plans (copies of Explanation of Benefits from the other plan). Failure to do so may result in claim denials or delay in the processing of your claim.

Group plans include:

- Plans sponsored by other employers
- Governmental programs of health care
- Collectively bargained plans
- Employee or employer organization plans

HOW COORDINATION OF BENEFITS WORKS

A plan without a coordinating provision is always the primary plan. If all plans have a coordinating provision:

- The plan covering the patient as an employee, rather than as a dependent, will be the primary plan
- If a child is covered under both parents' plan, then the plan covering the parent whose birthday occurs earlier in the year will be primary
- **In the case of a dependent child whose parents are divorced:**
  - The parent with legal custody of the child is primary/
  - If the custodial parent is remarried, the custodial parent's health coverage is primary. The non-custodial parent's health coverage is second, and the stepparent's health coverage is third.

Exception: If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, then that parent's policy would be primary.

- An active plan (one in which an employee is currently working) is primary over an in-active plan (a plan that a person might have as a retiree or inactive employee)
- If none of the previous rules determine primacy, the plan covering the person longer is the primary plan.

By applying for, paying participant contributions for, or accepting benefits under the plans, you agree that the claims administrators, in order to administer claims, have the right to:

- Obtain or share data needed to determine benefits under this or any other provision of the plans.
- Recover any sum paid above required by this or any other provision of the plans, from another plan which is liable for such amount but has not yet paid, or from you by request, by legal proceeding, or by withholding such amounts from future payments.

IF YOU ARE ELIGIBLE FOR MEDICARE AS AN ACTIVE EMPLOYEE

If you are covered under the Plan for health care benefits and are also eligible for Medicare benefits or have dependents who are Medicare-eligible:

- Due to end stage renal disease, the Plan will determine benefits without taking into account Medicare benefits for which that person is eligible during the first 30 consecutive months that person is eligible for Medicare benefits.
- Due to attainment of age 65, the plans will determine benefits without taking into account Medicare benefits.

RETIRED EMPLOYEES AND DEPENDENTS FOR WHOM MEDICARE IS THE PRIMARY PLAN

If you are retired and have attained age 65, Medicare is your primary plan, and you must enroll in Medicare, both Part A and Part B in order to be eligible for the Medicare Plans offered by the Employer.

CONTINUING COVERAGE

LEAVES OF ABSENCE

Generally, your health benefits do not continue while you are on a leave of absence, unless that leave is a military leave or an FMLA leave, as discussed below. Contact the Plan Administrator for additional information.

Uniformed Services Employment and Re-Employment Rights Act of 1994

The Uniformed Services Employment and Re-employment Rights Act, as amended (USERRA), requires the Plan to continue health coverage for a participant who is on a military leave of absence, as described below. These requirements apply to the health benefits provided for you and your dependents.

CONTINUATION OF COVERAGE:

You may elect to continue your health coverage for yourself and your dependents. For military leaves of less than 31 days, you will pay for your health benefits as if you were still at work. For military leaves of 31 days or more, the following applies:

- You may continue coverage by paying the required participant contributions to the Employer, until the earliest of the following:
  - 24 months from the last day of employment with the Employer
  - The day after you fail to return to work
  - The day the Plan terminates.
- The Employer will charge you up to 102 percent of the total cost of the health coverage.

REINSTATEMENT OF BENEFITS:

If your health benefits end during the military leave because you do not elect coverage under USERRA and you are rehired by the Employer, health benefits for you and your dependents will be reinstated if:

- You gave the Employer advance written or verbal notice of your military leave.
- The duration of all military leaves while you are employed with the Employer does not exceed Five years.

You and your dependents will only be subject to the balance of a waiting period, if appropriate, that was not yet satisfied before the military leave began. However, if an injury or illness occurs or is aggravated during the military leave, full Plan limitations will apply.

If your health coverage under the Plan terminates as a result of your eligibility for military health coverage and your order to active duty is canceled before active duty commences, these reinstatement rights will continue to apply.

Contact the Plan Administrator for more information about continuing health benefits during a military leave of absence.

Family and Medical Leave Act
Your health benefits will be continued during a leave of absence under the Family and Medical Leave Act of 1993, as amended (FMLA). The Plan Administrator will give you more detailed information about the FMLA. The FMLA allows you to take a leave of absence for up to a total of 12 work weeks in a 12-month period for one or more of the following reasons:

- The birth of your child and to care for the newborn child.
- The placement of a child with you for adoption or foster care
- To care for a family member (child, spouse, or parent) with a serious health condition
- Your own serious health condition that makes you unable to perform the functions of your job.
- Any qualifying exigency arising out of the fact that your spouse, child, or parent is a covered member in the Armed Forces on active duty (or has been notified of an impending call or order to active duty) in support of a contingency operation.

If eligible, you may also take leave for up to a total of 26 work weeks in a single 12-month period to care for a covered member of the Armed Forces with a serious injury or illness.

HEALTH BENEFITS COVERAGE WHILE ON FMLA LEAVE:
The Employer will continue your health benefits under the Plan during your FMLA leave just as if you were still employed. The cost of health coverage during an FMLA leave must be paid, and you must make all required participant contributions on an after-tax basis in accordance with the agreement reached between you and the Employer prior to the FMLA leave becoming effective. Alternatively, the Employer may collect the participant contributions in arrears after you return to work from FMLA leave.

A newly-acquired dependent is eligible for health coverage while your coverage is continued during an FMLA leave.

Continued health coverage ends on the earliest date that you:

- Terminate employment.
- Do not make required contributions.
- Exhaust your approved period of FMLA leave and do not return to work from the FMLA leave.

If your employment does not terminate during your FMLA leave, but you do not return to work once your FMLA leave ends, you can choose to continue health benefits under the COBRA continuation rules.
Reinstatement of Canceled Coverage Following FMLA Leave:
Upon your return to employment following an FMLA leave, any terminated health coverage will be reinstated as of the date of your return. You will not be required to satisfy any waiting period, if appropriate, to the extent that it had been satisfied prior to the start of the FMLA leave.

STATE FAMILY AND MEDICAL LEAVE LAWS:
The Employer's FMLA policy must comply with any state law that provides greater family or medical leave rights than those provided under its FMLA policy. If your leave qualifies under the FMLA and under a state law, you will receive the greater benefit.

IF THE EMPLOYER CHANGES BENEFITS:
If the Employer offers new benefits or changes its benefits while you are on an FMLA leave, you are eligible for the new or changed benefits, but participant contributions for those benefits may increase.

EXTENDED MEDICAL LEAVE:
At the discretion of the County, employees may be eligible for extended medical leave. Please contact the Department of Human Resources for more information.

CLAIMS & APPEALS

CLAIMS FILING

Each participant enrolled under the Plan receives an identification card. When using a preferred or contracted medical provider or when admitted to a preferred or contracted hospital, you must present your identification card. Upon discharge, you will be billed only for those charges not covered by the Plan. The preferred or contracted provider or hospital will bill the claims administrator directly for covered services. Payment for covered services will be made directly to the preferred or contracted provider or hospital.

If you use a non-preferred or non-contracted medical provider or are admitted to a non-preferred or non-contracted hospital that does not have a participating agreement with the claims administrator, you should inform the admitting personnel of your coverage. You must submit the bill to the claims administrator.

For health care expenses other than those billed by a preferred or contracted provider, you must use the claims forms available online, at the claims administrator's websites. Claims should include your name, identification, and group numbers exactly as they appear on your identification card. You must attach itemized bills to the claim form and file them directly with the claims administrator. You should keep a photocopy of all forms and bills for your records. The address to mail claims is on your medical ID card. You must make certain that the claim information is itemized to include dates, places, diagnoses, and nature of services or supplies.

TIMELINESS OF FILING

To receive benefits, a properly completed claim form, with any necessary reports and records, must be filed within 12-months of the date of service. Payment of claims will be made as soon as possible following receipt of the claim, unless there is incomplete or missing information. In this case, you will be notified of the reason for the delay. After this data is received, the claims administrator will complete claims processing.

NECESSARY INFORMATION

In order to process a claim, the claims administrator may need information from the provider of the service. You must agree to authorize the physician, hospital, or other provider to release necessary information. The claims administrator will consider such information confidential.
However, both the Plan and the claims administrator have the right to use this information to defend or explain a denied claim.

UNAUTHORIZED USE OF IDENTIFICATION CARD

If you permit your identification card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Unauthorized use could also result in termination of the coverage.

QUESTIONS ABOUT COVERAGE OR CLAIMS
If you have questions about coverage or claims, you should contact the claims administrator's customer service department. The Employer does not receive claim payment information from the claims administrator and cannot explain the processing of any claims. When contacting the claims administrator, you should be prepared to provide the information available on your identification card.

When asking about a claim, you must provide the following information:

- Your identification and group number
- Date of service
- Provider name (hospital or physician)

To find out if a medical provider is a preferred or contracted provider, you should consult the claims administrators' websites or call the claims administrators.

DETERMINATION OF ELIGIBILITY CLAIMS OR BENEFIT CLAIMS
There are two types of claims:

- Eligibility and enrollment claims – A claim to participate or enroll in the Plan or to change an election to participate mid-year.
- Benefit claims – A claim for a specific health benefit, which typically includes the initial request for benefits.

DETERMINATION OF ELIGIBILITY AND ENROLLMENT CLAIMS
All claims regarding your or your dependent's eligibility and enrollment for health benefits under the Plan are determined by the Plan Administrator, in its sole discretion.

DETERMINATION OF BENEFIT CLAIMS AND APPEALS
All benefit claims and appeals for the health (medical, dental, and vision) benefits offered under the Plan are determined in accordance with the claims and appeals procedures described below.

LEGAL ACTION
The claimant has the right to bring a civil action if he/she is not satisfied with the outcome of the claims and appeals procedure. The claimant may not initiate a legal action against the Plan until he/she has completed the claims and appeals process.

AUTHORIZED REPRESENTATIVE
A claimant may have an authorized representative act on his/her behalf with respect to a benefit claim or appeal by notifying the claims administrator in writing. The claims administrator will recognize a court order giving a person authority to submit claims and appeals on the claimant's behalf. The claims administrator may also recognize providers as authorized to act on the claimant's behalf under its procedures.

In the case of an urgent care claim or appeal, the claims administrator will automatically recognize a health care professional with knowledge of the claimant's medical condition (for example, the treating

physician) as his/her authorized representative, unless the claimant gives the claims administrator other instructions in writing.

Once the claimant has an authorized representative, the claims administrator will direct all information, notifications, etc. regarding the claim or appeal to the authorized representative. The claimant will receive copies of all notifications regarding decisions, unless he/she gives the claim administrator other instructions in writing.

Once the claimant has an authorized representative, all references in these claims and appeals procedures to "claimant" will include the authorized representative, where appropriate. An assignment for payment does not constitute an appointment of an authorized representative under these claims and appeals procedures.

Types of Benefit Claims
There are four types of health benefit claims, each with different time limits:

- Pre-service claims (other than urgent care claims): This is a claim for benefits under the Plan where the Plan requires that, to receive benefits from the Plan, in whole or in part, the claimant must obtain approval before receiving treatment or care.
- Urgent care claims: This is a pre-service claim for benefits that, if not decided quickly, could seriously jeopardize the claimant's life or health or ability to regain maximum function or would, in the opinion of a physician with knowledge of the claimant's medical condition, subject the claimant to severe pain that cannot be adequately managed without the benefits that are the subject of the claim.
- When the claims administrator receives a pre-service claim, they will decide whether it involves urgent care. A person acting on behalf of the Plan, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, will make this determination. However, if a physician with knowledge of the claimant's medical condition tells the claims administrator that the claim involves urgent care, the claims administrator will treat the pre-service claim as an urgent care claim.
- Post-service claims: This is a claim for benefits under the Plan after the claimant has received the benefits. Claims filed one year or more after the date of service will not be paid unless the claimant has proof of timely filing.
- Concurrent care claims: The Plan makes a concurrent care decision when they approve an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. If the claimant has been approved for an ongoing course of treatment, he/ she will be notified in advance if the approved course of treatment is intended to be terminated or reduced. The claimant will be provided with the notice in sufficient time to allow him/her the opportunity to appeal the decision and receive a decision on appeal before the termination or reduction takes effect.

If the claimant would like to extend an ongoing course of treatment that is a claim involving urgent care, a claim for such extension should be filed at least 24 hours before the end of the initially approved period of time or number of treatments.

Notifications for Benefit Claims

- Incorrectly filed pre-service (including urgent care) claims: If the claimant does not follow the correct procedures for filing a pre-service claim (including an urgent care claim), the claims administrator will notify him/her as soon as possible, but no later than five days after they receive the incorrectly filed pre-service claim and no later than 24 hours after it receives the incorrectly filed urgent care claim. The notification will describe the proper procedures for filing the claim.
- Timing of initial claims determination: The claimant will receive a written decision from the claims administrator regarding the claim as follows:
  - Urgent care claims: The claimant will receive a decision as soon as possible, taking into account the medical urgency, but no later than 72 hours after the claims administrator receives the claim, regardless of whether the claim is approved or denied, in whole or in part. If it is determined that additional information is needed to process the claim, the claimant will be notified and told the specific information needed no later than 24 hours after the claims administrator receives the claim. The claimant will have at least 48 hours to provide the requested information. The claimant will be notified of a decision as soon as possible, but no later than 48 hours after the requested information is received or, if earlier, the end of the deadline for providing the requested information. Because of the urgency of these claims, notice of a decision may be given verbally and followed up in writing no later than three days after the verbal notice.
  - Pre-service claims and post-service claims: For a pre-service claim, the claimant will receive a decision within a reasonable time appropriate to the medical circumstances, but no later than 15 days after the claims administrator receives the claim, regardless of whether the claim is approved or denied, in whole or in part. For a post-service claim, the claimant will receive a decision within a reasonable time, but no later than 30 days after the claims administrator receives the claim, whether the claim is approved or denied, in whole or in part.

If the claims administrator needs more time to process a pre-service claim or a post-service claim because of matters beyond the claims administrator's control, they may extend the initial period (15 days for a pre-service claim or 30 days for a post-service claim) for up to additional 15 days by notifying the claimant of the extension before the end of the initial period. The extension notice will explain the reason for the extension; the date the decision is expected to be made; and, if the extension is needed because the claimant did not submit information necessary to process the claim, the additional information needed. If the claimant is requested to provide additional information to process the claim, he/she will have at least 45 calendar days to provide the information. The days from the date the claimant is sent the extension notice to the due date for the requested information (or, if earlier, the date he/ she responds to the request) are not counted as part of the time period by which the claims administrator must make a decision.

- Concurrent care claims: For a claim to extend an ongoing course of treatment that is a claim involving urgent care, the claimant will receive a decision as soon as possible, taking into account the medical urgency, but no later than 24 hours after the claims administrator receives the claim, regardless of whether the claim is approved or denied, in whole or in part, provided the claimant files the claim at least 24 hours before the end of the initially approved period of time or number of treatments.

Any other request to extend an ongoing course of treatment will be decided according to the applicable time limits for urgent care claims, pre-service claims, and post-service claims.

- Notice of determination: If the claim is approved, the claims administrator will notify the claimant in writing, and he/she will receive an Explanation of Benefits as the notification. If the claim is denied, in whole or in part, the written notice will explain:
- The specific reason(s) for the denial.
- References to the specific Plan provisions on which the denial was based.
- Any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
- For medical claims, information sufficient to identify the claim– Any internal procedures or clinical information upon which the denial was based (or a statement that this information will be provided free of charge, upon request)
- If the denial is based on a medical necessity, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to the medical circumstances (or a statement that this explanation will be provided free of charge, upon request)
- A description of the Plan's appeal procedures and time limits applicable to such procedures (in the case of an urgent care claim, a description of the expedited review process), and the Plan's external review procedures, including a statement of the claimant's rights to bring a civil action following an adverse benefit determination on appeal.

APPEAL PROCESS FOR BENEFIT CLAIMS
Note that the following appeal process is for self-funded health benefits offered by Aetna, as well as dental and vision claims. Details regarding the appeal process for fully-insured medical and pharmacy benefits can be found in the incorporated documents.

Claimants have the right to file an appeal with the claims administrator following any adverse benefit determination, including any rescission of medical coverage.

Appeals will only be accepted by the claims administrator. The claims administrator's decisions are final, and the Employer will not review appeals regarding benefit claims, medical necessity, procedures or treatments considered experimental in nature, and/or non-FDA approved treatments or medications under the Plan.

The claimant must make a written appeal to the claims administrator within 180 days following receipt of an adverse benefit determination. Failure to comply with this important deadline may cause the claimant to forfeit any right to any further review of the claim under these procedures or in a court of law.

If the claim involves urgent care, the claimant may appeal the claim denial either verbally or in writing. All necessary information, including the appeal determination, will be communicated between the claimant and the claims administrator by telephone, facsimile, or other similar method and followed-up with written communication.

The appeal should include the group name, the claimant's name, and the ID number or other identifying information shown on the front of the Explanation of Benefits, as well as the following:

- The reasons for the appeal
- Any written comments, documents, records, or other information supporting the appeal, whether or not submitted in connection with the initial claim.

The claims administrator may call the claimant to obtain medical records and/or other pertinent information in order to respond to the appeal.

If requested, the claimant will be given reasonable access to, and copies of, all documents, records, or other information relevant to the claim, free of charge, and the identity of any medical expert consulted in connection with the initial claim (regardless of whether the expert's advice was used to deny the claim).

Upon receipt of the appeal, the claims administrator will make a full and fair review of the claim, taking into account all comments, documents, records, and other information submitted by the claimant (regardless of whether the information was submitted or considered in determining the initial claim). The review will not defer to the claims administrator's prior decision and will not be conducted by the person(s) who made the prior decision or his/her subordinate. If the claims administrator's claim denial was based on medical judgment, the claims administrator will consult with a medical professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was neither consulted in connection with its prior decision nor a subordinate of any such person. Before the claims administrator makes their appeal determination for a medical claim, the claimant will be provided, free of charge, any new or additional evidence considered, relied upon, or generated by the claims administrator (or at the direction of the claims administrator) or any new or additional rationale as soon as possible and in sufficient time to allow the claimant the opportunity to respond before the claims administrator issues its appeal determination.

TIMING OF APPEALS DETERMINATION

The claimant will receive a written notice from the claims administrator regarding the appeal as follows:

- Urgent care claims: The claimant will be notified as soon as possible, taking into account the medical urgency, but no later than 36 hours after the claims administrator receives the appeal, regardless of whether the claim is approved or denied, in whole or in part. Because of the urgency of these claims, the claimant may receive notice of an appeal determination verbally and followed up in writing no later than three (3) days after the verbal notice.

- Pre-service claims (other than urgent care claims): The claimant will be notified within a reasonable time appropriate to the medical circumstances, but no later than 15 days after the claims administrator receives the appeal, regardless of whether the appeal is approved or denied, in whole or in part.
- Post-service claims: The claimant will be notified within a reasonable time, but no later than 30 days after the claims administrator receives the appeal, regardless of whether the appeal is approved or denied, in whole or in part.
- Concurrent care claims: For a claim to extend an ongoing course of treatment that is a claim involving urgent care, the claimant will be notified as soon as possible, taking into account the medical urgency, but no later than 36 hours after the claims administrator receives the appeal.

Any other request to extend an ongoing course of treatment will be decided according to the applicable time limits for pre-service claims (no later than 15 days after the claims administrator receives the appeal) and post-service claims (no later than 30 days after the claims administrator receives the appeal).

NOTIFICATIONS FOR APPEALS

If the appeal is approved, the claims administrator will notify the claimant in writing. If the appeal is denied, in whole or in part, the written notice will explain:

- The specific reason(s) for the adverse benefit determination
- References to the specific Plan provisions on which the adverse benefit determination was based.
- 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.
- For medical claim information sufficient to identify the claim
- Any internal procedures or clinical information upon which the adverse benefit determination was based (or a statement that this information will be provided free of charge, upon request)
- If the adverse benefit determination is based on a medical necessity, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to the medical circumstances (or a statement that this explanation will be provided free of charge, upon request)
- The Plan's available review procedures, including information about the Plan's external review procedures. The notice will also state that the claimant have the right to bring a civil action after the claims and appeals process is exhausted

EXTERNAL REVIEW PROCESS

The claimant may request external review of any final adverse benefit determination that qualifies as set forth below. Subject to verification procedures that the claims administrator may establish, an authorized representative may act on the claimant's behalf in requesting and pursuing external review.

Requesting external review will have no effect on the claimant's rights to any other benefits under the Plan. External review is voluntary, and the claimant is not required to undertake it before pursuing legal

action. If the claimant chooses not to request external review, the Plan will not assert that the claimant has failed to exhaust his/her administrative remedies because of that choice.

The external review process gives the claimant the opportunity to have a review of the claims administrator's or Appeals Committee's determination on the appeal conducted pursuant to applicable federal law. The request will be eligible for external review if the following are satisfied:

- The Plan's internal claims and appeals processes have been exhausted; or The Plan's internal claims and appeals processes are deemed exhausted, as discussed above.
- The claim involves either (a) a medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment) as determined by the external reviewer, or (b) a rescission of coverage (whether or not the rescission has any effect on any particular benefit at the time). Medical judgment includes, but is not limited to, determinations based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit or the Plan's determination that a treatment is experimental or investigational.
- The claim is not for a denial of coverage based upon the claimant's eligibility for Plan participation.

The written notice that the claimant receives regarding the claims administrator's or Appeals Committee's adverse benefit determination on the appeal will describe the process to follow if the claimant wishes to request an external review and will include a copy of the Request for External Review form.

The claimant must submit the Request for External Review form to the claims administrator within four (4) months after he/she receives notice of the claims administrator's or Appeals Committee's adverse benefit determination on appeal. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday. The claimant also must include a copy of the claims administrator's or Appeals Committee's determination and all other pertinent information that supports the request for external review.

If the claimant requests external review, any applicable statute of limitations will be tolled while the external review is pending.

PRELIMINARY REVIEW:
Within five (5) business days after the claims administrator receives the Request for External Review form, it will conduct a preliminary review to determine the following: the claimant was covered under the Plan at the time the health benefit was requested or provided, the determination does not relate to eligibility for Plan participation, the claimant has exhausted the internal claims and appeals process (unless "deemed exhaustion" applies), and the claimant has provided all paperwork necessary to complete the external review.

Within one (1) business day after completion of the preliminary review, the claims administrator will issue the claimant a written notice of their determination. If the Request for External Review form is complete but not eligible for external review, the notice will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration

(toll-free number 866.444.EBSA [866.444.3272]). If the Request for External Review form is not complete, the notice will describe the information or materials needed to make the request complete, and the claimant will have until the later of the four (4)-month filing period, or the 48-hour period after he/she receives the notice, to submit the information or materials.

Referral to Independent Review Organization (IRO):
If the claims administrator determines that the request is eligible for external review, the claims administrator will assign an Independent Review Organization ("IRO"), accredited as required under federal law, to conduct the external review. The Plan must contract with at least three (3) IROs for assignments under the Plan and rotate review assignments among them. The IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review and will provide an opportunity for the claimant to submit in writing, within 10 business days following the date of receipt of the notice, additional information that the IRO must consider when conducting the external review. Within five (5) business days after the assignment to the IRO, the claims administrator will provide the IRO with all documents and information that the claims administrator or Appeals Committee considered in making its decision on the appeal.

If the claims administrator fails to provide the documents within the five (5)-day period, the IRO may unilaterally terminate external review and make a decision to reverse the claims administrator's or Appeals Committee's adverse benefit determination. If the IRO makes the decision to terminate external review, the IRO will, within one (1) business day of making its decision, notify the claimant, the claims administrator, and the Plan. Upon receipt of any information submitted by the claimant, the IRO must forward that information to the claims administrator within one (1) business day. The claims administrator may then reconsider the adverse benefit determination. If the claims administrator decides to reverse the adverse benefit determination, the claims administrator must provide written notice of its decision to the claimant and the IRO within one (1) business day after making the decision. The IRO will then terminate the external review.

IRO DECISION:
The IRO will review all of the information and documents received. In reaching a decision, the IRO will review the claim and not be bound by any decisions or conclusions reached during the claims administrator's internal claims and appeals process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- The claimant's medical records
- The attending health care professional's recommendation
- Reports from appropriate health care professionals and other documents submitted by the Plan, the claimant, or the treating provider.
- The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law.
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government or national or professional medical societies, boards, and associations.
- Any applicable clinical review criteria developed and used by the claims administrator, unless the criteria are inconsistent with the terms of the Plan or with applicable law

- The opinion of the IRO's clinical reviewer(s) after considering the information described above, to the extent the information or documents are available and the clinical reviewer(s) considers it appropriate.

The IRO will provide written notice of its Final External Review Decision within 45 days after receiving the Request for External Review form. The IRO will deliver its Final External Review Decision to the claimant, the claims administrator, and the Plan. The IRO's notice will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (e.g., the date or dates of service, the health care provider, the claim amount, the diagnosis code and its meaning, the treatment code and its meaning, and the reasons for the previous denials)
- The date the IRO received the external review assignment from the claims administrator and the date of the IRO's decision.
- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, that the IRO considered in making its determination.
- A discussion of the principal reason(s) for the IRO's decision, including the rationale for the decision, and any evidence-based standards that were relied upon by the IRO in making its decision.
- A statement that the determination is binding, except to the extent that other remedies may be available under state or federal law to either the Plan or the claimant.
- A statement that the claimant may still be eligible to seek judicial review of any adverse external review determination.
- Current contact information, including the telephone number, for any applicable office of health insurance consumer assistance or ombudsmen available to assist the claimant.

If the IRO's Final External Review Decision reverses the claims administrator's or Appeals Committee's adverse benefit determination, the Plan must immediately provide the health benefit (including immediately authorizing or immediately paying benefit) for the claim.

EXPEDITED EXTERNAL REVIEW PROCESS:
The claimant may request an expedited external review at the time he/she receives:

- An initial determination as stated in an Explanation of Benefits ("EOB") involving a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the claimant's life or health or would jeopardize his/her ability to regain maximum function and he/she has filed a request for an expedited internal appeal.
- An adverse benefit determination on appeal, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize his/her life or health or would jeopardize his/her ability to regain maximum function, or if the appeal determination concerns an admission, availability of care, continued stay, or health care item or service for which he/she received emergency services, but has not been discharged from a facility

Preliminary Review: Immediately upon receipt of the request for expedited external review, the claims administrator will conduct the preliminary review described above for standard external review. The claims administrator will immediately send the claimant a notice of its determination.

Referral to IRO for Expedited Review: If the claims administrator determines that the request for expedited external review is eligible for expedited external review, the claims administrator will assign an IRO. The claims administrator will provide or transmit all necessary documents and information considered in making its initial determination or the adverse benefit determination to the IRO electronically, by telephone, by fax, or by any other available expeditious method. The IRO will review the information and documents described above for standard external review and will provide a decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing the notice, the IRO will provide written confirmation of the decision to the claimant, the claims administrator, and the Plan.

If the IRO's decision reverses the claims administrator's or Appeals Committee's determination, the Plan must immediately provide the health benefit (including immediately authorizing or immediately paying benefits) for the claim.

IRO RECORDS:
After its Final External Review Decision, the IRO will maintain records of all claims and notices associated with the external review process for six (6) years. An IRO will make such records available for examination by the claimant, the Plan, or the state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

Qualified Medical Child Support Orders (QMCSO)

A State court or agency may require the County to provide Group Protection Plan coverage to children by issuing a medical support order. The County must determine whether the medical child support order is "Qualified".

To be considered a "Qualified" order it must contain the name and last known address of the Participant and each alternate recipient (Child) and the period to which the order applies. If the employee participant's eligibility requirements have not been met, the child's eligibility will begin upon the employee satisfying the eligibility requirements. The Gwinnett County Health Plan adds newly eligible participants for coverage the first of each month. Coverage for the child will be effective as of the first day of the month following the determination that the order is "Qualified" and all enrollment requirements have been met. The child will have the same continuation rights under COBRA as the covered employee participant. The County must comply with the terms of the order.

If the County receives a Medical Support Notice or Court order and determines that it is a QMCSO, we will inform the State agency of any outstanding enrollment requirements, and when Coverage under the Plan will begin. The County will provide the custodial parent or guardian of the child with information about the coverage under the Plan (Summary Plan Description) and any enrollment forms or documents necessary to start eligibility and make claims. The employee participant will be copied on this correspondence. The complete QMCSO Procedures are listed in this document. If you should have any question about QMCSOs or need additional information, please do not hesitate to contact the Benefits Division in Human Resources.

QMCSO PROCEDURES

I. Introduction

This document sets forth the procedures to be followed by the Gwinnett County Health Plan upon receipt of qualified medical child support orders (QMCSOs), including National Medical Support Notices. These QMCSO procedures have been developed in accordance with Section 609(a) of the Employee Retirement Income Security Act of 1974 (ERISA), which requires group health plans to establish administrative procedures for determining whether orders are QMCSOs and administering the provision of benefits under QMCSOs. They are designed to assist the plan administrator in determining whether a particular order is a QMCSO and in carrying out its responsibilities relating to QMCSOs.

A. QMCSO Defined

QMCSO is a judgment, decree, or order, issued by a court or through a state administrative process, that requires health plan coverage for the child of a participant (called an alternate recipient) and meets certain legal requirements. Such orders typically are issued as part of a divorce or as part of a state child support order proceeding. Federal law requires a group health plan to pay benefits in accordance with such an order, if it is qualified. A QMCSO may apply to an employer's major medical plan, as well as to other types of group health plans such as dental plans, vision plans, and health FSAs. In general, a child who is an alternate recipient under a QMCSO is to be treated like any other beneficiary under the plan.

State child support enforcement agencies are required to use the National Medical Support Notice when enforcing the provision of health care coverage to children under an employment-related group health plan. This is a standard form that was jointly developed by the DOL and HHS. When properly completed by the issuing agency, the Notice will constitute a QMCSO. Other orders are not required to follow a standard format.

In some cases, orders will refer to or require a plan to comply with state laws enacted in response to Section 1908A of the Social Security Act, which requires states to enact certain medical child support laws in order to receive federal Medicaid funds These state laws are designed to help state governments and non-employee parents obtain private-sector health coverage for children, including coverage under employer-sponsored group health plans.

B. Plan's Rights and Responsibilities Relating to QMCSOs

Plans are not required to provide coverage in accordance with child support or other court orders that are not qualified in accordance with ERISA §609(a). The plan administrator has the ultimate authority to determine whether an order meets the requirements of ERISA §609(a). If the order does not meet these requirements, the plan need not provide any benefits to the alternate recipient, unless the child is otherwise eligible or the order's deficiencies are corrected by the parties.

All actions related to QMCSOs must be made in accordance with these procedures and must be performed on a timely basis.

II. Procedures for Determining Whether Orders are QMCSOs

A. Upon Receipt of an Order

The procedures to be followed upon receipt of an order depend on whether the order is a National Medical Support Notice or another type of order.

1. Upon Receipt of a National Medical Support Notice

Upon receipt of a National Medical Support Notice, the plan administrator must:

- Promptly provide the participant and the alternate recipient named in the order (and their legal representatives, if any) with written notice of (a) the receipt of the Notice; and (b) the plan's QMCSO procedures; and
- Review the Notice to determine if it has been properly completed and meets the legal requirements of a QMCSO, using the Checklist attached to these procedures and the instruction to the employer and the plan administrator on the Notice itself.

Within 40 business days after the date of the Notice, or sooner if reasonable, the plan administrator must notify the participant, alternate recipient, state agency, and any legal representatives or other parties indicated in the Notice, using the spaces indicated on the Notice,
that either:

- The Notice is a QMCSO; or
- The Notice is not a QMCSO (the plan administrator's reasons for rejecting the Notice should be indicated in the space provided on the Notice).

This notification generally can be provided by sending copies of the completed Plan Administrator Response to the Notice to the parties. In addition, if the

Notice is determined to be a QMCSO, the parties must be provided with certain information, such as the effective date of the child's coverage (or the steps necessary to effectuate coverage), a description of the coverage, and any forms or documents necessary to enroll in the plan.

2. Upon Receipt of Any Other Order

   Upon receipt of an order other than a National Medical Support Notice, the plan administrator must:

   - promptly provide the participant and the alternate recipient named in the order (and their legal representatives, if any) with written notice of (a) the receipt of the order; and (b) the plan's QMCSO procedures; and
   - review the order to determine if it meets the legal requirements of a QMCSO.

   Within a reasonable time after receipt of the order (the time limits for reviewing the National Medical Support Notice will be used as a guideline), the plan administrator must notify the participant and alternate recipient that either:

   - the order is a QMCSO; or
   - the order is not a QMCSO (an explanation of the defective or missing provisions should be included).
   - Copies of the notification should also be provided to the parties' legal representatives, if any.

B. Upon Receipt of an Order

An alternate recipient may designate a representative to receive copies of notices that are sent to him or her with respect to an order.

C. Disputes

Within 30 days after the date of the plan administrator's notice as to whether an order is a QMCSO, the parties (or their legal counsel) will have the right to submit written comments regarding the determination. After considering any comments received, the plan administrator will make a final determination as to the qualified status of the order. If no comments are received during the 30-day period, the decision will become final.

D. Resubmitted Orders

If an order (including a National Medical Support Notice) is determined to not to be a QMCSO, the parties or agency may submit a revised order to cure the deficiencies. If a revised order is submitted, the evaluation process is repeated.

Article III. Additional Considerations

A. Forms and Information

Additional forms and information may be necessary to effectively administer benefits under an order that has been determined to be a QMCSO and to enroll the alternate recipient in the applicable plans. These forms and information include the following:

- The name and address of the alternate recipient's custodial parent, legal guardian, or other person(s) to whom the SPDs and other plan-related information and correspondence should be furnished following the alternate recipient's enrollment. Where an agency is involved (as in the case of a National Medical Support Notice), it may be necessary or appropriate to provide certain plan information and/or correspondence to the agency as well.

- A completed enrollment form, is required under the plan.

C. Alternate Recipient as Beneficiary

In general, the alternate recipient must be treated like any other beneficiary under each plan in which he or she is enrolled

- Unless a QMCSO is more restrictive, the alternate recipient should be given the same coverage as would be provided to any other dependent child under the plan.
- The alternate recipient should be treated as a qualified beneficiary and offered COBRA continuation coverage upon the occurrence of a COBRA qualifying event (such as the participant's termination of employment or the alternate recipient's ceasing to qualify as a dependent child under the plan due to age or student status).

D. Alternate Recipient as Participant

With respect to ERISA reporting and disclosure rules, the alternate recipient generally is to be treated like a participant under each plan in which he or she is enrolled. Therefore, the alternate recipient should be sent copies of all applicable ERISA-required disclosures, including the summary plan description, summary of material modifications, summary annual report, WHCRA notices, etc. These items generally should be furnished to the alternate recipient's custodial parent or guardian. (If the alternate recipient is an adult, the plan administrator may provide copies to both the alternate recipient and the custodial parent or guardian.) Where an agency is involved (as in the case of a National Medical Support Notice), it may be necessary or appropriate to provide copies of these items to the agency as well.

E. Effective Date of Enrollment

An alternate recipient generally will be enrolled in the plan as of the next regular enrollment date under the plan (i.e., the date on which the plan regularly adds new participants and beneficiaries) following the plan administrator's approval of an order as a QMCSO (or the date provided in the order, if later) and receipt of any necessary enrollment forms. (If an employee is eligible for the plan but is not enrolled, he or she will also be enrolled if his or her enrollment is necessary for the alternate recipient to have the coverage required under the QMCSO). However, if the employee has not yet satisfied the plan's waiting period, enrollment of the alternate recipient and employee will be delayed until the employee has completed the waiting period. Coverage is effective as of the date of enrollment.

F. Special Consideration - Child Already Enrolled

The parties may submit an order (including a National Medical Support Notice) that purports to require that a child be covered under a plan in which he or she is already enrolled. In this circumstance, the plan administrator should process the order under these procedures but should also inform the parties of the child's status as a current beneficiary under the plan.

CONTINUATION OF COVERAGE (FEDERAL LAW – COBRA) ACTIVE EMPLOYEES

A federal law, the *Consolidated Omnibus Budget Reconciliation Act of 1985,* as amended ("COBRA"), offers participants the opportunity to continue health coverage under the Plan in certain circumstances.

COBRA continuation coverage is a temporary continuation of health coverage when it otherwise would end because of a "qualifying event." After a qualifying event, COBRA continuation coverage is offered to each "qualified beneficiary." You, your spouse, and any dependent children could become qualified beneficiaries if you have coverage under the Plan on the day before a qualifying event and that coverage is lost because of the qualifying event. Qualified beneficiaries also include any children born to you or placed for adoption with you during the COBRA continuation period.

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

QUALIFIED BENEFICIARIES AND QUALIFYING EVENTS COVERED EMPLOYEE:
You are eligible for COBRA continuation coverage if you lose coverage under the Plan because of one of the following qualifying events:

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

SPOUSE OF COVERED EMPLOYEE:
Your spouse is eligible for COBRA continuation coverage if he/she loses coverage under the Plan because of one of the following qualifying events:

- Your hours of employment are reduced.
- Your employment ends for any reason other than gross misconduct.
- You die.
- You become divorced or legally separated from your spouse.
- You enroll in Medicare benefits (under Part A, Part B or both)

DEPENDENT CHILDREN:
Your dependent children are eligible for COBRA continuation if they lose coverage under the Plan because of one of the following qualifying events:

- Your hours of employment are reduced.
- Your employment ends for any reason other than gross misconduct.
- You die.
- You become divorced or legally separated from your spouse.
- Your child loses eligibility for coverage as a "dependent child" under the Plan.

- You enroll in Medicare benefits (under Part A, Part B or both) Notification of Qualifying Events.

The Plan offers COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred.

When the qualifying event is the end of your employment, the reduction in your work hours, your enrollment in Medicare, or your death, the Employer will notify the Plan Administrator of the qualifying event.

For other qualifying events (divorce or legal separation or a dependent child losing eligibility for coverage as a dependent child) or the occurrence of a second qualifying event, you or the qualified beneficiary must notify the Plan Administrator within 60 days after the date the qualifying event occurs or the day the qualified beneficiary loses coverage because of the qualifying event. If you or the qualified beneficiary fails to notify the Plan Administrator within this 60-day period, the dependent will not be entitled to elect COBRA continuation coverage. In addition, if any benefit claims are mistakenly paid for expenses incurred after the date health benefit coverage under the Plan would normally be lost because of the qualifying event, you will be required to reimburse the Plan for any payments mistakenly made.

HOW COBRA CONTINUATION COVERAGE IS OFFERED
After the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage is offered to each qualified beneficiary.

The Plan Administrator provides a COBRA enrollment notice by mail within 14 business days after receiving notice of the qualifying event, and each qualified beneficiary has an independent right to elect COBRA continuation coverage.

You may elect COBRA continuation coverage on behalf of your spouse, and parents may elect COBRA continuation coverage on behalf of their children. It is critical that anyone who may become a qualified beneficiary maintain a current address with the Plan Administrator to ensure that he/she receives a COBRA enrollment notice following a qualifying event. Qualified beneficiaries have 60 calendar days from the date coverage ends due to a qualifying event or from the date of the COBRA notice, whichever is later, to elect COBRA continuation coverage. If the qualified beneficiary fails to elect COBRA continuation coverage within the applicable timeframe, the opportunity to continue coverage under COBRA will be forfeited.

EFFECTIVE DATE OF COBRA CONTINUATION COVERAGE
If elected within the period allowed for the election, COBRA continuation coverage is effective retroactively to the date health coverage would otherwise have terminated due to the qualifying event, and the qualified beneficiary will be charged for COBRA continuation coverage in this retroactive period. However, if the qualified beneficiary waives COBRA continuation coverage and then revokes the waiver within the 60-day election period, the elected COBRA continuation coverage begins on the date the waiver is revoked.

HOW LONG COBRA CONTINUATION COVERAGE LASTS
COBRA continuation coverage is a temporary continuation of coverage. It lasts for up to a total of 36 months when the qualifying event is:

- Your death.
- Your divorce or legal separation.
- A dependent child losing eligibility as a dependent child COBRA continuation coverage generally lasts for up to a total of 18 months when the qualifying event is the end of your employment or reduction of work hours. This 18-month period of COBRA continuation coverage can be extended in two ways:

Disability Extension of 18-Month Period of COBRA Continuation Coverage:
If a qualified beneficiary in your family is determined by the Social Security Administration to be disabled, and you notify the Plan Administrator in a timely fashion, you and all qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months, if all of the following conditions are met:

- The COBRA qualifying event was your termination of employment or reduction in work hours.
- The qualified beneficiary is determined by the Social Security Administration to have been disabled at any time during the first 60 calendar days of COBRA continuation coverage, and the disability lasts at least until the end of the 18-month period of COBRA continuation coverage.
- A copy of the Notice of Award from the Social Security Administration is provided to the Plan Administrator within 60 calendar days of receipt of the notice and before the end of the initial 18 months of COBRA continuation coverage.
- An increased premium of 150 percent of the monthly cost of coverage is paid, beginning with the 19th month of COBRA continuation coverage.

Second Qualifying Event Extension of 18-Month Period of COBRA Continuation Coverage:
If another qualifying event occurs during the first 18 months of COBRA continuation coverage, your spouse and dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator.

This extension may be available to your spouse and any dependent children receiving COBRA continuation coverage if you die, get divorced or legally separated, or a dependent child is no longer eligible under the Plan as a dependent child, but only if the event would have caused your spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Medicare Extension for Dependents
If the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B, or both) within the 18 months before the qualifying event, COBRA continuation coverage for your dependents will last up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for 18 months from the date of termination of employment or reduction in work hours.

What COBRA Continuation Coverage Costs
COBRA participants must pay monthly premiums for coverage. Premiums are based on the full cost per covered person set at the beginning of the plan year, plus 2 percent for administrative costs. Dependents making separate elections are charged the same rate as a single employee.

An increased premium of 150 percent of the cost of coverage must be paid in the case of disability, beginning with the 19th month of COBRA continuation coverage.

Payment is due at enrollment, but there is a 45-day grace period from the date the qualified beneficiary mails the enrollment form to make the initial payment. The initial payment includes coverage for the current month, plus any previous month(s). Note that COBRA continuation coverage will not be effective until the qualified beneficiary actually pays the COBRA premium; if payment is not made with the enrollment, COBRA continuation coverage will be retroactively activated back to the date of the enrollment upon receipt of payment.

Ongoing monthly payments are due on the first of each month, but there is a 30-day grace period (for example, June payment is due June 1, but will be accepted if postmarked by June 30).

General Provisions
If you, your spouse, and/or dependent child(ren) elect COBRA continuation coverage:

- You can keep the same level of coverage you had as an active participant or choose a lower level of coverage.
- Coverage is effective as of the date of the qualifying event. However, if you waive COBRA continuation coverage and then revoke the waiver within the 60-day election period, the elected coverage begins on the date the waiver is revoked.
- You or your dependent may change coverage:
  - During the annual open enrollment period
  - If you have a Life Status Change
  - If you have a change in circumstance recognized by the Internal Revenue Service (“IRS”)
- You may enroll any newly-eligible spouse or child under Plan rules.

When COBRA Continuation Coverage Ends
COBRA continuation coverage ends when the first of the following events occurs:

- The qualified beneficiary reaches the maximum COBRA continuation period. Coverage for a newly-acquired dependent who has been added for the balance of a continuation period would end at the same time that your continuation period ends.
- The qualified beneficiary becomes covered under another medical plan not offered by the Employer.
- The qualified beneficiary fails to make participant contributions by the due date as required.
- The Employer stops providing any health benefits to any employee.
- The qualified beneficiary becomes enrolled in benefits under Medicare. This does not apply if it is contrary to the Medicare Secondary Payor Rules or other federal law.

- The qualified beneficiary dies.
- Any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving COBRA continuation coverage (such as fraud)
- The Social Security Administration determines that the qualified beneficiary is no longer disabled (if entitled to 29 months of COBRA continuation coverage under the special disability rule), in which case the extended portion of the COBRA continuation coverage will end with the month that begins more than 30 days after the Social Security Administration's determination.

TRADE ACT

Federal law provides for a tax credit for certain individuals who become eligible for Trade Adjustment Assistance ("TAA") benefits, particularly in the event of terminations of employment that are related to international trade, and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation ("PBGC"). Under these tax provisions, eligible individuals can either take a tax credit or get advance payment for a portion of the premiums paid for qualified health coverage, including COBRA continuation coverage.

In addition, if you initially decline COBRA continuation coverage and, within 60 days after your loss of qualified health coverage under the Plan, you are deemed eligible, by the U.S. Department of Labor or a state labor agency, for TAA benefits and the tax credit, you may be eligible for a special 60-day COBRA election period. The special election period begins on the first day of the month that you become TAA benefits-eligible if the election is made within six (6) months after the date of the TAA-related loss of qualified health coverage. If you elect COBRA continuation coverage during this special election period, COBRA continuation coverage will be effective on the first day of the special election period and end on the same day that it would have ended if COBRA continuation coverage had been elected during the regular election period available as a result of your trade-related termination of employment or reduction in work hours (generally, 18 months, unless you experience one of the events discussed under "When COBRA Continuation Coverage Ends" above).

If you receive a determination that you are TAA benefits-eligible, you must notify the Plan Administrator immediately. More information about these TAA provisions is available at doleta.gov/tradeact.

CONTINUATION OF COVERAGE (FEDERAL LAW—COBRA) RETIREES

The COBRA information in this section applies when a retiree's health coverage or the health coverage of a retiree's dependent under the Plan is ended.

QUALIFIED BENEFICIARIES AND QUALIFIED EVENTS

Covered Retiree:

You are eligible for COBRA continuation coverage if you lose your health coverage under the Plan because the Employer commences Chapter 11bankruptcy proceedings.

Spouse of Covered Retiree:

Your spouse is eligible for COBRA continuation coverage if he/she loses health coverage under the Plan because of one of the following qualifying events:

- You die.
- You become divorced or legally separated from your spouse.
- The Employer commences Chapter 11 bankruptcy proceedings.

Dependent Children:

Your dependent children are eligible for COBRA continuation if they lose health coverage under the Plan because of one of the following qualifying events:

- You die.
- You become divorced or legally separated from your spouse.
- Your child loses eligibility for coverage as a "dependent child" under the Plan.
- The Employer commences Chapter 11 bankruptcy proceedings.

NOTIFICATION OF QUALIFYING EVENTS

The Plan offers COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the Employer's Chapter 11 bankruptcy proceedings, the Employer will notify the Plan Administrator of the qualifying event. For other qualifying events, you or the qualified beneficiary must notify the Plan Administrator within 60 days after the later of the date the qualifying event occurs or the day the qualified beneficiary loses coverage because of the qualifying event. If you or the qualified beneficiary fails to notify the Plan Administrator within this 60-day period, the dependent will not be entitled to elect COBRA continuation coverage. In addition, if any benefit claims are mistakenly paid for expenses incurred after the date health benefit coverage under the Plan would normally be lost because of the qualifying event, you will be required to reimburse the Plan for any payments mistakenly made.

HOW COBRA CONTINUATION COVERAGE IS OFFERED
After the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage is offered to each qualified beneficiary.

The Plan Administrator provides a COBRA enrollment notice by mail within 14 days after receiving notice of the qualifying event, and each qualified beneficiary has an independent right to elect COBRA continuation coverage.

You may elect COBRA continuation coverage on behalf of your spouse, and parents may elect COBRA continuation coverage on behalf of their children. It is critical that anyone who may become a qualified beneficiary maintain a current address with the Plan Administrator to ensure that he/she receives a COBRA enrollment notice following a qualifying event.

Qualified beneficiaries have 60 days from the date coverage ends due to a qualifying event or from the date of the COBRA notice, whichever is later, to elect COBRA continuation coverage. If the qualified beneficiary fails to elect COBRA continuation coverage within the applicable timeframe, the opportunity to continue coverage under COBRA will be forfeited.

EFFECTIVE DATE OF COBRA CONTINUATION COVERAGE
If elected within the period allowed for the election, COBRA continuation coverage is effective retroactively to the date health coverage would otherwise have terminated due to the qualifying event, and the qualified beneficiary will be charged for COBRA continuation coverage in this retroactive period. However, if the qualified beneficiary waives COBRA continuation coverage and then revokes the waiver within the 60-day election period, the elected COBRA continuation coverage begins on the date the waiver is revoked.

HOW LONG COBRA CONTINUATION COVERAGE LASTS
COBRA continuation coverage is a temporary continuation of coverage. It lasts for up to a total of 36 months when the qualifying event is:

- Your death.
- Your divorce or legal separation.
- A dependent child losing eligibility as a dependent child.

In the case of a bankruptcy proceeding, COBRA continuation coverage generally lasts for you until the date of your death. For your spouse or dependent child(ren), COBRA continuation coverage ends on the earlier of:

- The date of your spouse’s or dependent child’s death
- 36 months after the date of your death

WHAT COBRA CONTINUATION COVERAGE COSTS

COBRA participants must pay monthly premiums for coverage. Premiums are based on the full cost per covered person set at the beginning of the plan year, plus 2 percent for administrative costs. Dependents making separate elections are charged the same rate as a single retiree.

Payment is due at enrollment, but there is a 45-day grace period from the date the qualified beneficiary mails the enrollment form to make the initial payment. The initial payment includes coverage for the current month, plus any previous month(s). Note that COBRA continuation coverage will not be effective until the qualified beneficiary actually pays the COBRA premium; if payment is not made with the enrollment, COBRA continuation coverage will be retroactively activated back to the date of the enrollment upon receipt of payment.

Ongoing monthly payments are due on the first of each month, but there is a 30-day grace period (for example, June payment is due June 1, but will be accepted if postmarked by June 30).

GENERAL PROVISIONS

If you, your spouse, and/or dependent child(ren) elect COBRA continuation coverage:

- You can keep the same level of coverage you had as a covered retiree or choose a lower level of coverage.
- You may change coverage during the annual open enrollment period or if you have a Life Status Change.
- You may enroll any newly-eligible dependent under Plan rules.

WHEN COBRA CONTINUATION COVERAGE ENDS

COBRA continuation coverage ends when one of the following events occurs:

- The qualified beneficiary reaches the maximum COBRA continuation period.
- The qualified beneficiary becomes covered under another medical plan not offered by the Employer.
- The qualified beneficiary fails to make participant contributions by the due date as required.
- The Employer stops providing any retiree medical benefits to any retiree.
- The qualified beneficiary dies.
- Any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (such as fraud).

PLAN'S PRIVACY PRACTICES

This section explains how medical information about you may be used or disclosed, and how you can get access to this information. Please review this section carefully.

HOW THE PLAN MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

The following is a list of the ways that the Plan may use and disclose health information about you. For each category of permitted use and disclosure, an explanation and some examples are provided. Not every possible use or disclosure is listed, but any permitted use or disclosure will fall into one of these categories:

Payment Functions:

The Plan may use or disclose health information about you to determine eligibility for Plan benefits, obtain premiums, facilitate payment for the treatment and services you receive from health care providers, determine Plan responsibility for benefits, and to coordinate benefits. For example, payment functions may include reviewing the medical necessity of health care services, determining whether a particular treatment is experimental or investigational, or determining whether a treatment is covered under the Plan.

Health Care Operations:

The Plan may use and disclose health information about you to carry out necessary insurance-related activities. For example, such activities may include underwriting, premium rating and other activities relating to Plan coverage, conducting quality assessment and improvement activities; submitting claims for stop-loss coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and business planning, management, and general administration.

Required by Law:

As required by law, the Plan may use and disclose your health information. For example, the Plan may disclose medical information when required by discovery, subpoena, or court order in a litigation proceeding which you or another person has commenced.

Public Health:

As required by law, the Plan may disclose your health information to public health authorities for purposes related to preventing and controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the U.S. Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Health Oversight Activities:

The Plan may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings related to oversight of the health care system.

Judicial and Administrative Proceedings:

The Plan may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement:
The Plan may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a subpoena or court order, or for other law enforcement purposes.

Coroners, Medical Examiners, and Funeral Directors:
The Plan may disclose your health information to coroners, medical examiners and funeral directors. For example, this may be necessary to identify a deceased person or determine the cause of death.

Organ and Tissue Donation:
The Plan may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues, as necessary.

Public Safety:
The Plan may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

National Security:
The Plan may disclose your health information for military, national security, prisoner, and government benefits purposes.

Workers' Compensation:
The Plan may disclose your health information as necessary to comply with workers' compensation or similar laws.

Marketing:
The Plan may contact you to give you information about health-related benefits and services that may be of interest to you.

Disclosures to Plan Sponsors:
The Plan may disclose your health information to the Sponsor of the Plan, for purposes of administering benefits under the Plan.

When the Plan May Not Use or Disclose Your Health Information
Except as described in the Notice of Privacy Practices, the Plan will not use or disclose your health information without written authorization from you. If you do authorize the Plan to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If you revoke your authorization, the Plan will no longer be able to use or disclose health information about you for the reasons covered by the written authorization, though the Plan will be unable to take back any disclosures already made with your permission.

STATEMENT OF YOUR HEALTH INFORMATION RIGHTS

Right to Request Restrictions:

You have the right to request restrictions on certain uses and disclosures of your health information. The Plan is not required to agree to the restrictions that you request. To request restrictions, you must submit the request in writing to the Manager, Employee/Retiree Benefits, Gwinnett County Department of Human Resources, 75 Langley Drive, Lawrenceville, GA 30046

Right to Request Confidential Communications:

You have the right to receive your health information through a reasonable alternative means or at an alternative location. To request confidential communications, you must submit the request in writing to the Manager, Employee/Retiree Benefits, Gwinnett County Department of Human Resources, 75 Langley Drive, Lawrenceville, GA 30046

Right to Inspect and Copy:

You have the right to inspect and copy your health information that may be used to make decisions about your Plan benefits. To inspect and copy such information, you must submit the request in writing to the Manager, Employee/Retiree Benefits, Gwinnett County Department of Human Resources, 75 Langley Drive, Lawrenceville, GA 30046

Right to Request Amendment:

You have the right to request that the Plan amend your health information that you believe is incorrect or incomplete. The Plan is not required to change your health information and, if the request is denied, the Plan will provide you with information about the denial and how you can disagree with the denial. To request an amendment, you must submit the request in writing to the Manager, Employee/Retiree Benefits, Gwinnett County Department of Human Resources, 75 Langley Drive, Lawrenceville, GA 30046

Right to Accounting of Disclosures:

You have the right to receive a list or “accounting of disclosures” of your health information made by the Plan, except that the Plan does not have to account for disclosures made for purposes of payment functions or health care operations, or made to you. To request this accounting of disclosures, you must submit a request in writing to the Manager, Employee/Retiree Benefits, Gwinnett County Department of Human Resources, 75 Langley Drive, Lawrenceville, GA 30046

INFORMATION AND COMPLAINTS

For more information regarding these rights and the privacy policies of the Plan, please review the Notice of Privacy Practices for the Plan. The Notice of Privacy Practices for the Plan is available from the Plan Administrator.

Complaints about how the Plan handles your health information should be directed to Director, Department of Human Resources, Gwinnett County, 75 Langley Drive, Lawrenceville, GA 30046, who has been designated as the Privacy Officer for the Plan. The Plan will not retaliate against you in any way for filing a complaint. All complaints to the Plan must be submitted in writing. If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the U.S. Department of Health and Human Services.

ADMINISTRATIVE INFORMATION

PLAN NAME
The official name of the Plan is the Gwinnett County Health Benefit Plan.

PLAN EMPLOYER/PLAN SPONSOR
The Employer/Sponsor for the Plan is:
Gwinnett County Board of Commissioners
75 Langley Drive
Lawrenceville, GA 30046

PLAN ADMINISTRATOR
The Plan Administrator for the Plan is:
Gwinnett County Board of Commissioners
Department of Human Resources
75 Langley Drive
Lawrenceville, GA 30046
Telephone: 770.822.7915

ADMINISTRATION INFORMATION
This section contains important information about how your benefits are administered.

AGENT FOR SERVICE OF LEGAL PROCESS
The agent for service of legal process under the Plan is:
Gwinnett County Board of Commissioners
75 Langley Drive
Lawrenceville, GA 30046
Attn: Director, Human Resources Department

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

PLAN YEAR
The plan year is a calendar year, which runs from January 1 to December 31.

CLAIMS ADMINISTRATORS AND AUTHORITY TO REVIEW CLAIMS
Your eligibility for health benefits is determined by the Plan. The Plan Administrator has full discretionary authority to interpret the terms of the Plan summarized in this SPD and determine your eligibility and benefit claims under the Plan's terms. In some cases, the Plan Administrator has delegated this authority.

The Plan Administrator has delegated its authority to determine benefit claims to the claims administrators listed above. Health benefits under the Plan are paid only if the claims administrator decides, in their discretion, that the claimant is entitled to them. The claims administrator has:

- The authority to make final determinations regarding benefit claims under the Plan.

- The discretionary authority to:
  - Interpret the Plan based on provisions and applicable law and make factual determinations about claims arising under the Plan.
  - Decide the amount, form, and timing of benefits.
  - Resolve any other matter under the Plan that is raised by a claimant or that is identified by the claims administrator.

In case of an appeal, the claims administrator's decision is final and binding on all parties to the full extent permitted under applicable law, unless the claimant later proves that the claims administrator's decision was an abuse of administrator discretion.

EMPLOYER'S RIGHT TO USE YOUR SOCIAL SECURITY NUMBER FOR ADMINISTRATION OF BENEFITS
The Employer has the right to use your Social Security number for benefit administration purposes, including tax reporting.

UNCLAIMED FUNDS
The applicable incorporated document will govern the handling of any unclaimed funds under the Plan.

NON-ASSIGNMENT OF BENEFITS
You cannot assign, pledge, borrow against, or otherwise promise any benefit payable under the Plan before receipt of that benefit payment. However, benefits will be provided to your child if required by a Medical Child Support Order or a National Medical Support Notice. In addition, subject to your written direction, all or a portion of benefits provided by the Plan may, at the option of the Plan, and unless you request otherwise in writing, be paid directly to the person rendering a service to you. Any payment made by the Plan in good faith pursuant to this provision shall fully discharge the Plan and the Employer to the extent of such payment.

This Summary Plan Description contains a summary in English of your plan rights and benefits under the Gwinnett County Group Health Insurance Plan. If you have difficulty understanding any part of this Summary Plan Description, contact the Plan Administrator at 770.822.7915.