YOUR GROUP DENTAL PLAN

GUILFORD COUNTY SCHOOLS

(REVISED 01/01/2009) FOR THE PROTECTION OF YOU AND YOUR FAMILY
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Guilford County Schools hereby establishes a Plan for payment of certain dental expenses for the benefit of its eligible employees and the eligible dependents of such employees, as hereinafter defined.

The purpose of this Plan Document and Summary Plan Description (also called the “SPD”) is to set forth the provisions of the Plan. It is intended that the terms of this Plan are legally enforceable and that the Plan be maintained for the exclusive benefit of eligible employees and their covered dependents.

Guilford County Schools has full discretionary authority to interpret and apply all Plan provisions, including, but not limited to, all issues concerning eligibility for and determination of benefits. Guilford County Schools may contract with an independent administrative firm to process claims, maintain Plan data, and perform other Plan connected services; however, final authority to construe and apply the provisions of the Plan rests exclusively with the Guilford County Schools. Decisions of Guilford County Schools, made in good faith, shall be final and binding.

The following pages describe the benefits to which the covered individuals are entitled, to whom benefits are payable, and the other provisions of the Plan.

Guilford County Schools
GUILFORD COUNTY SCHOOLS
DENTAL REIMBURSEMENT PLAN
(REVISED 01/01/2009)

SCHEDULE OF BENEFITS

DENTAL BENEFITS FOR COVERED EMPLOYEES AND COVERED DEPENDENTS

The Guilford County Schools Dental Reimbursement Plan is a direct reimbursement program. Payments for Covered Dental Expenses must be issued before consideration by the Plan. Please refer to the Claim Reimbursement provisions for further explanation.

- Lifetime Orthodontic Benefit: $1,000.00
- Maximum Calendar Year Benefit: $1,000.00

(The Maximum Calendar Year Benefit of $1,000.00 will include benefits for Orthodontic reimbursement. The Plan does not require a deductible to be satisfied before benefits are determined.)

- Percentage Payable: 50% of eligible expenses up to $1,000.00

(An Employee who elects Coverage when initially eligible will not be subject to any waiting period for Covered Dental Expenses. Also, if an Employee has Eligible Dependents and elects Dependent Coverage when initially eligible, the Covered Dependents will not be subject to any waiting period for Covered Dental Expenses. Please refer to the Enrollment Provisions for Coverage changes and waiting periods.)

COVERED DENTAL EXPENSES

The following are Covered Dental Expenses if provided by or under the direction of a Dentist licensed to practice by the state in which he/she practices.

PREVENTIVE BENEFITS:
1. Routine oral examination;
2. Prophylaxis (routine cleaning);
3. Fluoride Treatment;
4. X-rays (full-mouth series or bite-wing x-rays); and
5. Sealants applied to permanent molars.

BASIC BENEFITS:
1. Extractions, including surgical removal of teeth;
2. Amalgam, silicate, plastic and composite restorations (fillings); and
3. Repair or recementing of a Prosthesis. This will include crowns, onlays, inlays, dentures, bridgework and veneers.
SCHEDULE OF BENEFITS (continued)

COVERED DENTAL EXPENSES (continued)

MAJOR BENEFITS:

1. Periodontics (treatment of gums and bones supporting the teeth, which includes cleanings and scalings)
2. Endodontics (pulp and root canal therapy);
3. Prosthesis (crowns, onlays, inlays, dentures, bridgework and veneers):
4. Crowns, jackets, and cast restorations for treatment of carious lesions (tooth decay) which cannot be restored with amalgam, silicate, plastic and composite restorations;
5. Denture adjustments and relining; and
6. Implants.

The Plan will consider the date the Implant(s) is placed as the date of service(s) for all follow-up treatment, which will include the placement of a temporary or permanent prosthesis.

ORTHODONTIC BENEFITS: Provides the necessary treatment for the correction of malocclusions and skeletal and dental abnormalities. This will include an appliance for spliniting and treatment for Temporomandibular Joint Syndrome (TMJ). The Plan will limit the initial downpayment for orthodontic expenses to 20% of the contract fee, with the remaining balance being considered on a monthly basis spread over the estimated treatment period. The Plan will apply this formula to orthodontic treatment that began prior to the date of coverage, to determine if any orthodontic expenses would be eligible for consideration after the date of coverage. The Plan will not consider Orthodontic expenses, if determined to be incurred prior to the date of coverage.

LIMITATIONS AND EXCLUSIONS

The Plan will not provide reimbursement for the following dental expenses:

1. Expenses incurred for services which were rendered before the effective date of coverage;
2. Expenses covered by Legislative acts such as Workers' Compensation, Medicare, or by any statute;
3. Expenses covered by another plan shall be subject to Coordination of Benefits and Subrogation;
4. Hospital care, surgery, or other expenses covered under the state of North Carolina medical plan or any other group medical care plan;
5. Dental education expenses;
6. Prescription drugs, in-home dental supplies or equipment;
7. Services purely for cosmetic purposes; rather than health reasons;
8. Replacement of lost or stolen removable orthodontic appliances, or retainers; and
9. Replacement of Prosthesis less than three years old.
SUMMARY PLAN DESCRIPTION

The following information together with the information given on the following pages of this booklet is intended to furnish a Summary Plan Description.

PLAN NAME

GUILFORD COUNTY SCHOOLS DENTAL REIMBURSEMENT PLAN

Hereinafter sometimes referred to as "Plan"

The Plan Sponsor and Administrator is the Guilford County Schools, whose address is 712 North Eugene Street, Post Office Box 880, Greensboro, North Carolina 27402-0880 and whose telephone number is (336) 370-8092.

The Employer Identification Number (EIN) of the Plan Sponsor is 56-6000522.

The Plan is a Welfare Plan providing Dental Care Coverages.

The Plan is administered by the Plan Administrator. The Plan Administrator may employ persons or firms to process claims and perform other Plan connected services.

The Plan Supervisor provides consulting services to the Guilford County Schools in connection with the operation of the Plan and performs such other functions, including the processing and payment of claims, as may be delegated to it. The Plan Supervisor is Benefit Plan Services, Inc., Post Office Box 2793, High Point, North Carolina, 27261 and whose telephone number is (336) 889-2003.

It is not anticipated that it will be necessary to have a lawsuit about the Plan; however, if a lawsuit is to be brought, legal process may be served on the Plan Administrator.

The requirements for being covered under the Plan, the provisions concerning termination of coverage, a description of the plan benefits (including any limitations and exclusions which may result in reduction or loss of benefits) are shown on the following pages of this booklet.

Contributions to the cost of the Plan are made by the Plan Sponsor and the Participating Employees. Such Employee contributions are based on a fixed rate and are subject to change with written notice to the Employee of such change.

Funds for payment of dental claims are deposited into an account from which claims are paid. All funds received by the account shall be applied toward the payment of claims and reasonable expenses for the administration of the Plan.

Payments by Eligible Employees for inclusion in the Plan shall be delivered to the account by the Plan Sponsor as general funds for the payments of claims and expenses of the Plan without allocation or attribution.

The fiscal records of this Plan are maintained on the basis of plan years ending on December 31st.

The procedure to be followed in presenting claims for benefits under the Plan is described on a following page entitled Claim Reimbursement provisions.
SUMMARY PLAN DESCRIPTION (continued)

If a claim for benefits is denied or partially denied, the Plan Supervisor will notify the claimant in writing. The written decision will:

a. give the specific reason or reasons for denial;

b. make specific reference to Plan provisions on which the denial is based;

c. provide a description of any additional information necessary to perfect the claim and an explanation of why it is necessary; and

d. provide an explanation of the Plan's claim review procedure.

HOW TO APPEAL DENIAL OF A CLAIM

If a claim for benefits is denied or partially denied or is not acted on within ninety (90) days of filing of proof of loss, the claimant, or his/her duly authorized representative, may:

a. request a review upon written application to the Plan Supervisor;

b. review pertinent documents; and

c. submit issues and comments in writing.

Any such request for a review must be mailed to the Plan Supervisor within ninety (90) days after receipt by the claimant of a written notification of denial of a claim or within one hundred and fifty (150) days from the date the claim was made and not acted on.

Upon notice of the above request, the Plan Supervisor shall refer the complete claim file to the Claims Review Committee of the Guilford County Schools. The Claims Review Committee shall consist of at least three disinterested employees of the Guilford County Schools who are appointed by the Superintendent of the Guilford County Schools to serve on the Committee.

A majority decision on the claim will be made by the Claims Review Committee no later than sixty (60) days after receipt of a request for review from the claimant, unless special circumstances (such as a decision by the Claims Review Committee that a hearing should be held on the matter) require an extension of time for processing, in which case, a decision shall be rendered as soon as possible, but not later than one hundred and twenty (120) days after receipt by the Plan Supervisor of the request for review. The decision on review shall be in writing and shall include specific reasons for the decision and specific references to the pertinent Plan provisions on which the decision is based.

NOTICE OF HIPAA PRIVACY STANDARD AND PRACTICES

This Notice of Privacy Practices ("Notice") is made in compliance with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). The Plan is required by law to take reasonable steps to ensure the privacy of a Covered Person’s Protected Health Information ("PHI"), as defined below, and to inform a Covered Person about:

1. the Plan's uses and disclosures of PHI;
2. a Covered Person’s privacy rights with respect to his/her PHI;
3. the Plan's duties with respect to a Covered Person’s PHI;
4. a Covered Person’s right to file a complaint with the Plan and with the Secretary of HHS; and
5. the person or office to contact for further information about the Plan's privacy practices.
NOTICE OF HIPAA PRIVACY STANDARD AND PRACTICES (continued)

The term "Protected Health Information" (PHI) includes all "Individually Identifiable Health Information" transmitted or maintained by the Plan, regardless of form (oral, written or electronic).

The term "Individually Identifiable Health Information" means information that:

- Is created or received by a dental care provider, dental plan, employer or dental care clearinghouse;
- Relates to the past, present or future dental care or condition of a Covered Person; the provision of dental care to a Covered Person; or the past, present or future payment for the provision of dental care to a Covered Person; and
- Identifies the Covered Person, or with respect to which there is a reasonable basis to believe the information can be used to identify the Covered Person.

Section 1. Notice of PHI Uses and Disclosures

1.1 Required PHI Disclosures

Upon a Covered Person’s request, the Plan is required to give him/her access to certain PHI to inspect and copy it and to provide him/her with an accounting of disclosures of PHI made by the Plan. For further information pertaining to a Covered Person’s rights in this regard, see Section 2 of this Notice.

The Plan must disclose a Covered Person’s PHI when required by the Secretary of HHS to investigate or determine the Plan's compliance with the Privacy Standards.

1.2 Permitted uses and disclosures to carry out treatment, payment and dental care operations

The Plan, its business associates, and their agents/subcontractors, if any, will use or disclose PHI without a Covered Person’s consent, authorization or opportunity to agree or object, to carry out treatment, payment and dental care operations. The Plan will disclose PHI to a business associate only if the Plan receives satisfactory assurance that the business associate will appropriately safeguard the information.

In addition, the Plan may contact a Covered Person to provide information about treatment alternatives or other dental-related benefits and services that may be of interest to a Covered Person. The Plan will disclose PHI to the Plan Sponsor for purposes related to treatment, payment and dental care operations. The Plan Sponsor has amended its plan documents to protect a Covered Person’s PHI as required by the Privacy Standards. The Plan Sponsor will obtain an authorization from a Covered Person if it intends to use or disclose his/her PHI for purposes unrelated to treatment, payment and dental care operations.

Treatment is the provision, coordination or management of dental care and related services by one or more dental care providers. It also includes, but is not limited to, consultations and referrals between one or more of the Covered Person’s providers.

For example, the Plan may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for a Covered Person’s dental X-rays from the treating dentist.
Payment means activities undertaken by the Plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the Plan, or to obtain or provide reimbursement for the provision of dental care. Payment includes, but is not limited to, actions to make eligibility or coverage determinations, billing, claims management, collection activities, subrogation, reviews for dental necessity and appropriateness of care.

For example, the Plan may tell a dentist whether a Covered Person is eligible for coverage or what percentage of the bill might be reimbursed by the Plan.

Dental care operations means conducting quality assessment and improvement activities, population-based activities relating to improving dental or reducing dental care costs, contacting dental care providers and patients with information about treatment alternatives, reviewing the competence or qualifications of dental care professionals, evaluating dental plan performance, underwriting, premium rating and other insurance activities relating to creating, renewing or replacing dental insurance contracts or dental benefits. It also includes conducting or arranging for dental review, legal services and auditing functions including fraud and abuse detection and compliance programs, business planning and development, business management and general administrative activities.

For example, the Plan may use information about a Covered Person’s claims to project future benefit costs or audit the accuracy of its’ claims processing functions.

1.3 A disclosure that requires a Covered Person be given an opportunity to agree or disagree prior to the disclosure

The Plan may disclose to a family member, other relative, close personal friend of a Covered Person or any other person identified by a Covered Person, PHI directly relevant to such person's involvement with a Covered Person’s care or payment for his/her dental care when a Covered Person is present for, or otherwise available prior to, a disclosure and a Covered Person is able to make dental care decisions, if:

- The Plan obtains the Covered Person’s agreement;
- The Plan provides a Covered Person with the opportunity to object to the disclosure and he/she fails to do so; or
- The Plan infers from the circumstances, based upon professional judgment, that a Covered Person does not object to the disclosure.

The Plan may obtain a Covered Person’s oral agreement or disagreement to a disclosure. However, if a Covered Person is not present, or the opportunity to agree or object to the disclosure cannot practically be provided because of a Covered Person’s incapacity or an emergency circumstance, the Plan may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the Covered Person, and, if so, disclose only PHI that is directly relevant to the person's involvement with his/her dental care.

1.4 Uses and disclosures for which authorization or opportunity to agree or object is not required

Use and disclosure of a Covered Person’s PHI is allowed without his/her authorization or opportunity to agree or object under the following circumstances:

a. When required by law, provided that the use or disclosure complies with and is limited to the relevant requirements of such law.
1.4 Uses and disclosures for which authorization or opportunity to agree or object is not required (continued)

b. When permitted for purposes of public health activities, including disclosures to (i) a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect and (ii) a person subject to the jurisdiction of the Food and Drug Administration (FDA) regarding an FDA-regulated product or activity for the purpose of activities related to the quality, safety or effectiveness of such FDA-regulated product or activity, including to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI also may be disclosed to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if authorized by law.

c. Except for reports of child abuse or neglect permitted by part (b) above, when required or authorized by law, or with a Covered Person’s agreement, the Plan may disclose PHI about a Covered Person to a government authority, including a social service or protective services agency, if the Plan reasonably believes a Covered Person to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Covered Person that such a disclosure has been or will be made unless (i) the Plan believes that informing a Covered Person would place him/her at risk of serious harm or (ii) the Plan would be informing a Covered Person’s personal representative, and the Plan believes that a Covered Person’s personal representative is responsible for the abuse, neglect or other injury, and that informing such person would not be in the Covered Person’s best interests. For the purposes of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure generally may be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

d. The Plan may disclose a Covered Person’s PHI to a dental oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of: (i) the dental care system, (ii) government benefit programs for which dental information is relevant to beneficiary eligibility, (iii) entities subject to government regulatory programs for which dental information is needed to determine compliance with program standards, or (iv) entities subject to civil rights laws for which dental information is needed to determine compliance.

e. The Plan may disclose a Covered Person’s PHI in the course of a judicial or administrative proceeding in response to an order of a court or administrative tribunal, provided that the Plan discloses only the PHI expressly authorized by such order, or in response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court of administrative tribunal if certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to a Covered Person, and the notice provides sufficient information about the proceeding to permit a Covered Person to raise an objection, and the time to object has expired and either no objections were raised or any objections were resolved in favor of disclosure by the court or tribunal.
NOTICE OF HIPAA PRIVACY STANDARD AND PRACTICES (continued)

1.4 Uses and disclosures for which authorization or opportunity to agree or object is not required (continued)

f. The Plan may disclose a Covered Person’s PHI to a law enforcement official when required for law enforcement purposes. The Plan may disclose PHI as required by law, including laws that require the reporting of certain types of wounds. Also, the Plan may disclose PHI in compliance with (i) a court order, court-ordered warrant, or a subpoena or summons issued by a judicial officer, (ii) a grand jury subpoena, or (iii) an administrative request, including an administrative subpoena or summons, a civil or authorized investigative demand, provided certain conditions are satisfied. PHI may be disclosed for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose a Covered Person’s PHI in response to a law enforcement official's request if a Covered Person was, or is suspected to be, a victim of a crime. Further, the Plan may disclose a Covered Person’s PHI if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Plan's premises.

g. The Plan may disclose PHI to a coroner or medical examiner for the purpose of identifying a deceased Covered Person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

h. The Plan may use or disclose PHI for research, subject to certain conditions.

i. When consistent with applicable law and standards of ethical conduct, the Plan may use or disclose PHI if the Plan, in good faith, believes the use or disclosure: (i) is necessary to prevent or lessen a serious and imminent threat to health or safety of a Covered Person or the public and is to person(s) able to prevent or lessen the threat, including the target of the threat, or (ii) is needed for law enforcement authorities to identify or apprehend a Covered Person, provided certain requirements are met.

j. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this Notice, uses and disclosures will be made only with written authorization from a Covered Person, subject to his/her right to revoke such authorization. A Covered Person may revoke an authorization at any time, provided his/her revocation is done in writing, except to the extent that the Plan has taken action in reliance upon the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Section 2: Rights of a Covered Person

2.1 Right to Request Restrictions on PHI Uses and Disclosures

A Covered Person may request the Plan to restrict uses and disclosures of his/her PHI to carry out treatment, payment or dental care operations, or to restrict disclosures to family members, relatives, friends or other persons identified by a Covered Person who are involved in his/her care or payment for his/her dental care. However, the Plan is not required to agree to a Covered Person’s requested restriction.
2.1 Right to Request Restrictions on PHI Uses and Disclosures (continued)

If the Plan agrees to a requested restriction, the Plan may not use or disclose PHI in violation of such restriction, except that, if a Covered Person requested a restriction and later are in need of emergency treatment and the restricted PHI is needed to provide the emergency treatment, the Plan may use the restricted PHI, or it may disclose such information to a dental care provider, to provide such treatment to a Covered Person. If restricted PHI is disclosed to a dental care provider for emergency treatment, the Plan must request that such dental care provider not further use or disclose the information.

A restriction agreed to by the Plan is not effective to prevent uses or disclosures when required by the Secretary of HHS to investigate or determine the Plan's compliance with the Privacy Standards or uses or disclosures that are otherwise required by law.

The Plan may terminate its agreement to a restriction, if:

- A Covered Person agrees to or requests the termination in writing;
- A Covered Person orally agree to the termination and the oral agreement is documented; or
- The Plan informs a Covered Person that it is terminating its agreement to a restriction, except that such termination is only effective with respect to PHI created or received after the Plan has informed the Covered Person of the termination.

If the Plan agrees to a restriction, it will document the restriction by maintaining a written or electronic record of the restriction. The record of the restriction will be retained for six years from the date of its creation or the date when it last was in effect, whichever is later.

A Covered Person or his/her personal representative will be required to request restrictions on uses and disclosures of a Covered Person’s PHI in writing. Such requests should be addressed to the Privacy Official.

2.2 Right to Request Confidential Communications of PHI

A Covered Person may request to receive communications of PHI from the Plan by alternative means or at alternative locations if a Covered Person clearly states that the disclosure of all or part of the information to which the request pertains could endanger the Covered Person. The Plan will accommodate all such reasonable requests. However, the Plan may condition the provision of a reasonable accommodation on:

- When appropriate, information as to how payment, if any, will be handled; and
- Specification by a Covered Person of an alternative address or other method of contact.

A Covered Person or his/her personal representative will be required to request confidential communications of a Covered Person’s PHI in writing. Such requests should be addressed to the Privacy Official.

2.3 Right to Inspect and Copy PHI

A Covered Person has a right to inspect and obtain a copy of his/her PHI contained in a "designated record set," for as long as the Plan maintains PHI in the designated record set.
2.3 Right to Inspect and Copy PHI (continued)

"Designated Record Set" means a group of records maintained by or for a dental plan that is enrollment, payment, claims adjudication and computer system records maintained by or for a dental plan; or used in whole or in part by or for the dental plan to make decisions about a Covered Person. Information used for quality control or peer review analyses and not used to make decisions about a Covered Person is not in the designated record set.

The Plan will act on a request for access no later than 30 days after receipt of the request. However, if the request for access is for PHI that is not maintained or accessible to the Plan on-site, the Plan must take action no later than 60 days from the receipt of such request. The Plan must take action as follows: if the Plan grants the request, in whole or in part, the Plan must inform a Covered Person of the acceptance and provide the access requested. However, if the Plan denies the request, in whole or in part, the Plan must provide a Covered Person with a written denial. If the Plan cannot take action within the required time, the Plan may extend the time for such action by no more than 30 days if the Plan, within the applicable time limit, provides a Covered Person with a written statement of the reasons for the delay and the date by which it will complete its action on the request.

If the Plan provides access to PHI, it will provide the access requested, including inspection or obtaining a copy, or both, of a Covered Person’s PHI in a designated record set. The Plan will provide a Covered Person with access to the PHI in the form or format requested if it is readily producible in such form or format; or, if it is not, in a readable hard copy form or such other form or format as agreed to between a Covered Person and the Plan. The Plan may provide a Covered Person with a summary of the PHI requested, in lieu of providing access to the PHI or may provide an explanation of the PHI to which access has been provided in certain circumstances. The Plan will arrange with a Covered Person for a convenient time and place to inspect or obtain a copy of the PHI, or mail a copy of the PHI at a Covered Person’s request. If a Covered Person requests a copy of PHI or agrees to a summary or explanation of PHI, the Plan will impose a reasonable, cost-based fee.

If the Plan denies access to PHI in whole or in part, the Plan will, to the extent possible, give a Covered Person access to any other PHI requested, after excluding PHI as to which the Plan has grounds to deny access. If access is denied, a Covered Person or his/her personal representative will be provided with a written denial setting forth the basis for the denial, if applicable, a statement of a Covered Person’s review rights, including a description of how he/she may exercise those review rights and a description of how he/she may complain to the Plan or to the Secretary of the HHS. If a Covered Person requests review of a decision to deny access, the Plan will refer the request to a designated licensed dental care professional for review. The reviewing official will determine, within a reasonable period of time, whether to deny the access requested. The Plan will promptly provide a Covered Person with written notice of that determination.

If the Plan does not maintain the PHI that is the subject of a Covered Person’s request for access, and the Plan knows where the requested information is maintained, the Plan will inform a Covered Person where to direct the request for access.

A Covered Person or his/her personal representative will be required to request access to a Covered Person’s PHI in writing. Such requests should be addressed to the Privacy Official.
2.4 Right to Amend PHI

A Covered Person has the right to request the Plan to amend his/her PHI or a record about his/her in a designated record set for as long as the PHI is maintained in the designated record set.

The Plan may deny a Covered Person’s request for amendment if it determines that the PHI or record that is the subject of the request:

- Was not created by the Plan, unless a Covered Person provides a reasonable basis to believe that the originator of PHI is no longer available to act on the requested amendment;
- Is not part of the designated record set;
- Would not be available for a Covered Person’s inspection under the Privacy Standards; or
- Is accurate and complete.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply within that deadline provided that the Plan, within the original 60-day time period, gives a Covered Person a written statement of the reasons for the delay and the date by which it will complete its action on the request. If the Plan accepts the requested amendment, the Plan will make the appropriate amendment to the PHI or record that is the subject of the request by, at a minimum, identifying the records in the designated record set that are affected by the amendment and appending or otherwise providing a link to the location of the amendment. The Plan will timely inform a Covered Person that the amendment is accepted and obtain his/her identification of and agreement to have the Plan notify the relevant persons with which the amendment needs to be shared as provided in the Privacy Standards.

If the request is denied in whole or part, the Plan must provide a Covered Person with a written denial that (i) explains the basis for the denial, (ii) sets forth a Covered Person’s right to submit a written statement disagreeing with the denial and how to file such a statement, (iii) states that, if a Covered Person does not submit a statement of disagreement, he/she may request that the Plan provide his/her request for amendment and the denial with any future disclosures of the PHI that is the subject of the amendment, and (iv) includes a description of how a Covered Person may complain to the Plan or to the Secretary of HHS. The Plan may reasonably limit the length of a statement of disagreement. Further, the Plan may prepare a written rebuttal to a statement of disagreement, which will be provided to a Covered Person. The Plan must, as appropriate, identify the record or PHI in the designated record set that is the subject of the disputed amendment and append or otherwise link a Covered Person’s request for an amendment, the Plan's denial of the request, his/her statement of disagreement, if any, and the Plan’s rebuttal, if any, to the designated record set. If a statement of disagreement has been submitted, the Plan will include the above-referenced material, or, at the Plan's election, an accurate summary of such information, with any subsequent disclosure of the PHI to which the disagreement relates. If a Covered Person does not submit a written statement of disagreement, the Plan must include his/her request for amendment and its denial, or an accurate summary of such information with any subsequent disclosure of the PHI only if requested by a Covered Person.

A Covered Person or his/her personal representative will be required to request amendment to his/her PHI in a designated record set in writing. Such requests should be addressed to the Privacy Official. All requests for amendment of PHI must include a reason to support the requested amendment.
2.5 Right to Receive an Accounting of PHI Disclosures

At a Covered Person’s request, the Plan will provide him/her with an accounting of disclosures by the Plan of his/her PHI during the six years prior to the date on which the accounting is requested. However, such accounting need not include PHI disclosures made: (a) to carry out treatment, payment or dental care operations; (b) to a Covered Person about his/her own PHI; (c) incident to a use or disclosure otherwise permitted or required by the Privacy Standards; (d) pursuant to an authorization; (e) to certain persons involved in a Covered Person’s care or payment for his/her care; (f) to notify certain persons of a Covered Person’s location, general condition or death; (g) as part of a Limited Data Set (as defined in the Privacy Standards), which largely relates to research purposes; or (h) prior to the compliance date of April 14, 2004. A Covered Person may request an accounting of disclosures for a period of time less than six years from the date of the request.

The accounting will include disclosures of PHI that occurred during the six years (or such shorter time period, if applicable) prior to the date of the request for an accounting, including disclosures to or by business associates of the Plan. Except as otherwise provided below, for each disclosure, the accounting will include:

- The date of the disclosure;
- The name of the entity or person who received the PHI and, if known, the address of such entity or person;
- A brief description of the PHI disclosed; and
- A brief statement of the purpose of the disclosure that reasonably informs a Covered Person of the basis for the disclosure, or, in lieu of such statement, a copy of a written request for disclosure.

If during the period covered by the accounting, the Plan has made multiple disclosures of PHI to the same person or entity for a single purpose, the accounting may, with respect to such multiple disclosures, provide the above-referenced information for the first disclosure; the frequency, periodicity or number of the disclosures made during the accounting period; and the date of the last disclosure.

If during the period covered by the accounting, the Plan has made disclosures of PHI for a particular research purpose for 50 or more Covered Persons, the accounting may, with respect to such disclosures for which a Covered Person’s PHI may have been included, provide certain information as permitted by the Privacy Standards. If the Plan provides an accounting for such research disclosures, and if it is reasonably likely that a Covered Person’s PHI was disclosed for such research activity, the Plan shall, at his/her request, assist in contacting the entity that sponsored the research and the researcher.

If the accounting cannot be provided within 60 days after receipt of the request, an additional 30 days is allowed if a Covered Person is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If a Covered Person requests more than one accounting within a twelve month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting unless a Covered Person withdraws or modifies the request for a subsequent accounting to avoid or reduce the fee.

A Covered Person or his/her personal representative will be required to request an accounting of his/her PHI disclosures in writing. Such requests should be addressed to the Privacy Official.

2.6 The Right To Receive a Paper Copy of This Notice Upon Request

A Covered Person has a right to obtain a paper copy of this Notice upon request. Upon request a paper copy of this Notice will be furnished by the Privacy Official.
2.7 A Note About Personal Representatives

A Covered Person may exercise his/her rights through a personal representative. A Covered Person’s personal representative will be required to produce evidence that the Covered Person has given them authority to act on his/her behalf before that person will be given access to a Covered Person’s PHI or allowed to take any action for a Covered Person. Proof of such authority may include, but is not limited to, the following:

a. a power of attorney for dental care purposes, notarized by a notary public;

b. a court order of appointment of the person as the conservator or guardian of a Covered Person; or

c. an individual who is the parent of a minor child.

The Plan retains discretion to deny access to a Covered Person’s PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Section 3: The Plan's Duties

3.1 Notice

The Plan is required by law to maintain the privacy of PHI and to provide a Covered Person with notice of its legal duties and privacy practices with respect to PHI.

This Notice is effective immediately and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change the terms of this Notice and to make the new revised notice provisions effective for all PHI that it maintains, including any PHI created, received or maintained by the Plan prior to the date of the revised notice. If a privacy practice is changed, a revised version of this Notice will be provided to all Covered Persons then covered by the Plan. If agreed upon between the Plan and a Covered Person, the Plan will provide a Covered Person with a revised Notice electronically. Otherwise, the Plan will distribute a paper copy of the revised Notice to all Covered Persons.

Any revised version of this Notice will be distributed within 60 days of any material change to the uses or disclosures, the Covered Person's rights, the duties of the Plan or other privacy practices stated in this Notice. Except when required by law, a material change to any term of this Notice may not be implemented prior to the effective date of the revised notice in which such material change is reflected.

3.2 Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

a. disclosures to or requests by a dental care provider for treatment;

b. uses or disclosures made to a Covered Person;

c. disclosures made to the Secretary of HHS.

d. uses or disclosures that are required by law;

e. uses or disclosures that are required for the Plan's compliance with the Privacy Standards; and

f. uses or disclosures made pursuant to an authorization.
3.2 Minimum Necessary Standard (continued)

This Notice does not apply to information that has been de-identified. De-identified information is dental information that does not identify a Covered Person and with respect to which there is no reasonable basis to believe that the information can be used to identify a Covered Person. It is not individually identifiable health information.

In addition, the Plan may use or disclose Summary Dental Information to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group dental plan. Summary dental information summarizes the claims history, claims expenses or type of claims experienced by a Covered Person for whom a plan sponsor has provided dental benefits under a group dental plan, and from which identifying information has been deleted in accordance with the Privacy Standards.

Section 4: A Covered Person’s Right to File a Complaint With the Plan or the HHS Secretary

If a Covered Person believes that his/her privacy rights have been violated, a Covered Person may complain to the Plan. Any complaint must be in writing and addressed to the Privacy Official.

A Covered Person also may file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services, Atlanta Federal Center, Suite 3B70, 61 Forsyth Street, SW., Atlanta, GA 30303-8909. Voice Phone (404) 562-7886. Fax (404) 562-7881. TDD (404) 331-2867.

The Plan will not retaliate against a Covered Person for filing a complaint.

Section 5: Whom to Contact at the Plan for More Information

If a Covered Person has any questions regarding this Notice or the subjects addressed in it, he/she may contact the Privacy Official.

Privacy Official: Patty A. Kinkade, Director of Benefits
Address: 712 North Eugene Street, Greensboro, NC 27402
Telephone: (336) 370-8092

Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA. A Covered Person may find these rules at 45 Code of Federal Regulations Parts 160 and 164. This Notice attempts to summarize the Privacy Standards. The Privacy Standards will supersede any discrepancy between the information in this Notice and the Privacy Standards.
SECURITY STANDARDS FOR THE PROTECTION OF ELECTRONIC HEALTH INFORMATION (the “SECURITY STANDARDS”)

The Plan will comply with the Security Standards for the Protection of Electronic Health Information (the “Security Standards”) issued pursuant to the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). Disclosure of Electronic Protected Health Information (“Electronic PHI”) to the Plan Sponsor for Plan Administration Functions as follow:

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

- Implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;

- Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate Security Measures to protect the Electronic PHI; and

- Report to the Plan any Security Incident of which it becomes aware.

Any terms not otherwise defined in this amendment shall have the meanings set forth in the Security Standards.
COVERED EMPLOYEE

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION DATE

ELIGIBILITY FOR COVERED EMPLOYEE: All regular, full time Employees in Active Service at their customary place of employment who work at least 30 hours per week for the Plan Sponsor will be eligible for coverage on the first day of the month following employment. Retired, part-time, temporary or seasonal Employees are not eligible.

EFFECTIVE DATE OF INDIVIDUAL COVERAGE: Coverage will become effective for a Covered Employee on the date of eligibility provided he/she is in Active Service on that date, otherwise his/her effective date will be deferred until his/her return to Active Service.

TERMINATION OF COVERED EMPLOYEE'S COVERAGE: Subject to any rights to continuation coverage (PHSA), a Covered Employee's coverage will terminate at the end of the month on the earliest of the following dates:

a. Upon termination of Active Service, except that in the event the Covered Employee is absent on account of sickness or injury, Active Service will terminate for the purpose of this coverage on such later date as the Plan Sponsor may determine.

b. On the date the Covered Employee enters the military, naval or air force of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding one month in any Calendar Year.

c. When the Covered Employee ceases to be in a class eligible for coverage.

d. On the termination date of the Plan.

CONTINUATION DURING FAMILY AND MEDICAL LEAVE (FMLA): The Plan will comply at all times with the FMLA. During an approved leave taken under FMLA, coverage will be maintained under the Plan on the same conditions as coverage would be provided if the Covered Employee had been continuously employed during the entire leave period.

If coverage is terminated during the FMLA leave and the Employee returns to work in accordance with the terms of the FMLA, the coverage type in effect at the time of the FMLA leave will be reinstated on the date the Employee returns to work on a full-time basis.

If the Guilford County Schools has a sick leave policy that exceeds the allowable FMLA period, coverage under the Plan will continue until the maximum sick leave period is reached.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA): If a Covered Employee is on leave for military services, he/she may continue coverage under the Plan as required by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Under USERRA, Covered Employees on military leave for less than 31 days may be required to pay the same cost charged to Active Employees, if any, for such coverage.

If the leave is for 31 days or more, the Covered Employee will be allowed to continue coverage for up to 24 months from the date of the military leave. The monthly cost for coverage will be the same as determined under COBRA. Coverage under the Plan will end on: 1. the date payment for coverage is not paid within 30 days of each monthly due date or 2. the day after the date the Covered Employee was required to return to employment with the Plan Sponsor.

No exclusion or waiting periods may be imposed with reinstatement of coverage upon reemployment as required under USERRA.
COVERED DEPENDENTS

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION DATE

ELIGIBILITY FOR DEPENDENT COVERAGE: A Covered Employee who has Dependents will be eligible to have his/her Dependents covered on whichever of the following dates occurs last: (a) The date the Employee is eligible for coverage, if on that date he/she has such Dependents; or (b) The date the Covered Employee gains a Dependent; if on that date he/she is covered by the Plan. In the event a husband and wife are both eligible to be covered by the Plan as Covered Employees, one, but not both, may elect coverage for the Dependent Children. Upon the death or termination of employment of the Covered Employee who has elected the Dependent coverage, the remaining Covered Employee may then elect the Dependent Coverage.

EFFECTIVE DATE OF DEPENDENT COVERAGE: A Covered Employee may elect to have his/her Dependents covered by signing an enrollment form. The effective date of Dependent Coverage will be the same as the effective date of the Covered Employee if Dependent Coverage is applied for when the Employee is initially eligible.

The Employee must be covered for Employee benefits in order to be eligible for Dependent Coverage. If a Covered Employee has Dependent Coverage and acquires another Dependent, coverage on that Dependent is effective on the date the Dependent is acquired.

Refer to the section entitled Enrollment Provisions for requirements applicable to adding Dependent Coverage after the initial eligibility.

TERMINATION OF COVERED DEPENDENT'S COVERAGE: Subject to any rights to continuation coverage (PHSA), a Covered Dependent's coverage will terminate at the end of the month on the earliest of the following dates:

a. When the coverage of the Covered Employee is terminated;
b. When the Covered Employee ceases to be in a class of Covered Employees eligible for Dependent Coverage;
c. When the Covered Employee ceases to make the required contribution for Dependent Coverage;
d. When the Covered Dependent ceases to meet the definition of a Dependent;
e. When a Covered Dependent Child becomes eligible as a Covered Employee;
f. When a Covered Dependent Spouse becomes eligible as a Covered Employee;
g. When Dependent Coverage is discontinued under the Plan; or
h. On the termination date of the Plan.
ENROLLMENT PROVISIONS

INITIAL ENROLLMENT: An Employee is eligible for coverage when a completed enrollment form is furnished to the Guilford County Schools. The cost for Employee Only Coverage is paid for by the Guilford County Schools. An Employee may apply for Dependent Coverage at this time and agree to (1) payroll deduction for the cost of Dependent Coverage and (2) maintain Dependent Coverage until the next Plan Anniversary of January 1st, except

An Eligible Employee who has Eligible Dependents, but does not elect Dependent Coverage when initially offered, his/her Eligible Dependents will be subject to a one year waiting period for Major and Orthodontic benefits from the date Dependent Coverage is elected. If an Eligible Employee initially waives coverage or a Covered Employee discontinues coverage on himself/herself and later wants to enroll in the Plan, he/she will have to wait until the next Annual Enrollment period to elect coverage and will be subject to a one year waiting period for Major and Orthodontic benefits.

A Covered Person may change his/her Coverage Type during a Calendar Year only as follows:

1. A Dependent Child is no longer an Eligible Dependent under the Plan;
2. A Covered Employee gets married during the Calendar Year;
3. A Covered Employee becomes Legally Separated, Divorce or marriage is annulled;
4. The death of a Covered Employee’s Spouse or Dependent Child;
5. A Covered Employee has a Dependent Child by birth or adoption;
6. A Covered Employee is required by court order to provide dental coverage for his/her Dependent Child(ren);
7. A Covered Employee’s Spouse or Dependent Child has an employment status change;
8. A Covered Employee, Spouse or Dependent Child employment changes from part-time to full-time or full-time to part-time status;
9. A Covered Employee, Spouse or Dependent Child has a change in residence or work site; or
10. A Covered Employee, Spouse or Dependent Child becomes entitled to Medicare or Medicaid

If a Covered Employee previously waived Dependent Coverage on his/her Eligible Dependents, those Eligible Dependents will be subject to a one year waiting period for Major and Orthodontic benefits from the date coverage is elected.

ALTERNATIVE DENTAL PLAN: The Guilford County Schools offers an Alternative Dental Plan to Eligible Employees. An Eligible Employee will not be covered under this Plan if the Alternative Dental Plan is elected. If an Eligible Employee elects the Alternative Dental Plan and later wants to elect Coverage under this Plan, he/she will be subject to a one year waiting period for the Orthodontic benefit.

ANNUAL ENROLLMENT: Prior to the beginning of each new Calendar Year, Guilford County Schools will establish a time period for the Annual Enrollment. During this Annual Enrollment period a Covered Employee may change his/her Dependent Coverage election. If an election to add Dependent Coverage is selected, a one year waiting period will apply to Major and Orthodontic benefits to those Eligible Dependents.

The necessary enrollment forms will be furnished to Covered Employees wanting to make a change. No action is required for Covered Employees not wanting to make a change.
Continuation coverage as described in this section is offered in compliance with the requirements of the Public Health Services Act (PHSA), and any amendments thereto. PHSA requires the Plan to offer a qualified beneficiary the opportunity for a temporary extension of coverage (called "continuation coverage") at group rates in certain instances where coverage under the Plan would otherwise end. It is the intent of the Plan to provide all rights under PHSA to all qualified beneficiaries. If any provision of this section is contrary to PHSA, such provision is hereby amended to conform to the minimum requirements thereof. This notice is intended to inform Covered Employees and their Covered Dependents of their rights and obligations under the continuation coverage provisions of the law.

A qualified beneficiary is an Employee, Employee’s Spouse, and/or Dependent Children who were covered under the Plan on the day coverage terminated (called “qualifying event date”). If a Covered Employee under continuation coverage is able to add Dependent Coverage as allowed under the Open Enrollment Provision of the Plan, those Covered Dependents will not be considered qualifying beneficiaries. If the Covered Employee ends continuation coverage under the Plan for any reason, non-qualifying beneficiaries’ coverage under the Plan will end as of that date. A child who is born to a Covered Employee, or is placed for adoption with the Covered Employee during a period of continuation coverage is a qualified beneficiary.

Covered Employees and Covered Dependents under the Plan will each have the right to choose continuation coverage for up to 18 months, if the loss of group dental coverage is due to the Covered Employee's termination of employment or reduction in hours of employment (for reasons other than gross misconduct by the Covered Employee).

If you are a Covered Spouse or a Covered Dependent Child under the Plan, you have the right to choose continuation coverage for yourself for up to 36 months if you lose group dental coverage under the Plan for any of the following reasons:

1. The death of the Covered Employee;
2. Divorce or legal separation of the Covered Employee; or
3. The Covered Dependent Child is no longer an eligible Dependent Child under the Plan.

If a Covered Employee was entitled to Medicare benefits due to age before his/her initial qualifying event date, the maximum 36 months continuation coverage period for a Covered Spouse or Covered Dependent Children will be reduced by the time period the Covered Employee has been entitled to Medicare, but the continuation coverage period will not be less than 18 months from the initial qualifying event date. If a Covered Employee becomes entitled to Medicare benefits due to age after his/her initial qualifying event date, the maximum continuation coverage period for a Covered Spouse or Covered Dependent Children will be 18 months from the initial qualifying event date, except if a second qualifying event occurs during the initial 18 months of continuation coverage.

An 18 month extension of coverage will be available to a Covered Spouse and Covered Dependent Children who elect continuation coverage if a second qualifying event occurs during the initial 18 months of continuation coverage. The maximum period of continuation coverage available when a second qualifying event occurs will be 36 months from the initial qualifying event date. Second qualifying events will include the Covered Employee’s death, divorce or legal separation of the Covered Employee, or a Covered Dependent Child is no longer an eligible Dependent Child under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the initial qualifying event had not occurred. A qualified beneficiary must provide written notice of the occurrence of the second qualifying event within 60 days.
A qualified beneficiary who is determined to be disabled by the Social Security Administration and the determination date is before the 60th day of the initial qualifying event date, continuation coverage may be extended from 18 months to 29 months from the initial qualifying event date. A qualified beneficiary must provide a copy of the disability determination notice from Social Security Administration within 60 days after the latest of:

1. The date of the Social Security Administration disability determination;
2. The date on which the qualified beneficiary would lose coverage under the Plan during the initial 18 month period of continuation coverage; or
3. The earliest date on which the qualified beneficiary is informed by the Plan of his/her obligation to provide the Social Security Administration notice of disability (notice is included in the general notice, summary plan description and termination of coverage notice).

If a qualified beneficiary is eligible for the 11 months extension of continuation coverage and later becomes entitled to Medicare, coverage under the Plan will end as of the date of Medicare entitlement. If any other qualified beneficiaries took the extension of continuation coverage, they will be eligible to continuation coverage until the additional 11 months has ended. If a qualified beneficiary is determined by Social Security Administration to no longer be disabled, he/she must provide written notice to the Plan within 30 days of the determination date by the Social Security Administration. Extension of continuation coverage will end 30 days after the qualified beneficiary is determined not to be disabled by the Social Security Administration.

Covered Employees or Covered Dependents have the responsibility to inform the Plan Administrator within 60 days of the date of a divorce, legal separation or a Covered Dependent Child is no longer an eligible Dependent Child under the Plan. A Covered Employee or Covered Dependent must provide written notice of the date a divorce, legal separation or the name of a Covered Dependent Child who is no longer an eligible Dependent Child under the Plan. If the Plan Administrator does not receive written notice within 60 days of the date of the divorce, legal separation or a Covered Dependent Child is no longer an eligible Dependent Child under the Plan, the Plan will not allow continuation coverage.

The Plan Administrator has the responsibility to notify the Plan Supervisor of a Covered Employee's death, termination of employment, reduction in hours, or Medicare entitlement. If during the initial 18 months of continuation coverage a second qualifying event were to occur, the Covered Dependent should provide written notice of the second qualifying event within 60 days. In no event will the continuation coverage last beyond 36 months from the initial qualifying event date of PHSA.

An approved leave of absence under the Family and Medical Leave Act of 1993 (FMLA) is not considered a qualifying event. A qualifying event will occur on either the last date the maximum period under the qualified FMLA leave ends or the date the Covered Employee states he/she will not return to employment. If the Plan Sponsor provides a leave of absence period greater than the 12 weeks as required under FMLA, the Covered Employee must continue to make the required contribution, otherwise coverage will end and no qualifying event will occur to continue coverage under PHSA.

When the Plan Administrator is notified that a qualifying event has occurred, PHSA notification and an election form will be mailed to the Covered Employee and/or the Covered Dependents of their right to choose continuation coverage. If the Covered Employee has Dependent Coverage, the notification will be addressed to the Covered Employee, Covered Spouse and Covered Dependent Children. The law allows Covered Employees and/or Covered Dependents at least a 60 day election period from the qualifying event date, or the date of the election notice if later, to apply for continuation coverage. If a Covered Employee and/or Covered Dependent does not elect continuation coverage that is postmarked within the 60 day election period, coverage under the Plan will end as of the qualifying event date.
To elect continuation coverage, a qualified beneficiary must complete the election form and return within the 60 day election period. Each qualified beneficiary has a separate right to elect continuation coverage. For example, a Covered Spouse may elect continuation coverage even if the Covered Employee does not. Continuation coverage may be elected for only one, several, or for all Dependent Children who are qualified beneficiaries. A parent or legal guardian may elect to continue coverage on behalf of any Covered Dependent Children. The Covered Employee or employee’s spouse may elect continuation coverage on behalf of all of the qualified beneficiaries.

Qualified beneficiaries do not have to show they are insurable to choose continuation coverage. However, the Plan requires a qualified beneficiary to pay for continuation coverage provided that the charge does not exceed 102% of the cost of the Plan for similarly situated Covered Employees and Covered Dependents for whom a qualifying event has not taken place. For the extension of coverage past the 18 Months allowed for totally disabled persons, the cost will be 150% from the 19th through the 29th Month.

If a qualified beneficiary elects continuation coverage, payment for coverage is not required to be sent with the election form. However, a qualified beneficiary must make the first payment for coverage postmarked not later than 45 days after the date the election form is signed requesting coverage. (This is the date the election form is postmarked, if mailed.) The first payment (for whole months) must be for the period beginning with the qualifying event date up to the next monthly due date following the date payment is mailed. A qualified beneficiary is responsible to make sure the amount of the first payment is correct. Please contact the Plan Supervisor to confirm the correct amount of the first payment. Thereafter, payments are due on a monthly basis and must be postmarked within 30 days of each monthly due date, which is the day of the qualifying event date. The qualifying event date will be the 1st day of the month, each monthly due date will begin on the 1st.

If the first payment, or any subsequent payment is not received on time, continuation coverage will terminate as of the last date for which payment has been made for. If the monthly payment for continuation coverage is $5.00 or 10% less than the required monthly amount, which ever is greater, it will be considered an insignificant underpayment. The Plan will return the underpayment to the qualified beneficiary. The qualified beneficiary must forward the correct amount postmarked within 30 days from the date notice of the insignificant underpayment is mailed, otherwise coverage will end as of the due date. If payment is more than $5.00 less or more than 10% less than the required monthly amount, which ever is greater, it will be considered non-payment.

The Plan will not provide continuation coverage until payment is received and only for the period for which continuation coverage is paid. If the Plan receives a check that is returned by the bank due to insufficient funds, this is considered non-payment. The Plan will forward the returned check to the qualified beneficiary. The qualified beneficiary must forward payment postmarked within 30 days from the due date, otherwise coverage will end as of the due date.

If a qualified beneficiary waived continuation coverage, he/she will be allowed to elect continuation coverage if requested within the 60 day election period. The qualified beneficiary must notify the Plan Supervisor in writing of the change. The date continuation coverage will begin will be the date the qualified beneficiary elects coverage. There will be no coverage during the period coverage was waived. If the Plan Supervisor is not informed within the 60 day election period, the Plan will not allow continuation coverage. The qualified beneficiary will be subject to a one year waiting period for Major and Orthodontic benefits beginning on the date continuation coverage is elected.
The law also provides that continuation coverage may be terminated for any of the following reasons:

1. When the Company no longer provides group dental coverage to any of its Employees;
2. When the qualified beneficiary fails to make premium payment within the time specified;
3. When the qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B or both) after electing continuation coverage;
4. When the qualified beneficiary becomes, after electing continuation coverage, under another group dental plan that does not include a pre-existing conditions clause that applies to the qualified beneficiary;
5. In the case of a qualified beneficiary who has extended his/her coverage to 29 months because of disability, thirty days after the date the qualified beneficiary is no longer disabled; or
6. When the time specified for continuation coverage has expired.

The Plan will not send monthly billing statements to the qualified beneficiary. It is the responsibility of the qualified beneficiary to remit the correct monthly payment postmarked within 30 days of each monthly due date.

The Plan will not pro-rate payment for a coverage period less than one month or if the qualified beneficiary becomes covered under Medicare or another group dental plan.

If a Covered Employee discontinued coverage on a Covered Spouse in anticipation of a divorce or legal separation, it will not be considered a qualifying event. The actual date of the divorce or legal separation will be considered a qualifying event. The spouse or representative must notify the Plan Supervisor within 60 days, otherwise the Plan will not allow continuation coverage.

All written notices of event changes should be mailed to: Alan Peters, Benefit Plan Services, Inc., Post Office Box 2793, High Point, NC 27261. Telephone number: (336) 889-2003.

If a Covered Employee and/or a Covered Dependent has any questions, he/she should contact Alan Peters at (336) 889-2003. Also, if a Covered Employee has a change in marital status, or a Covered Employee or a Covered Dependent has a change in their mailing addresses, please notify the Plan Administrator.

**GENERAL PROVISIONS**

**ENTIRE PLAN DOCUMENT:** This SPD, and any amendments thereto, constitutes the terms and provisions of coverage under this Plan. These documents shall not be deemed to constitute a contract of any type between the Plan Sponsor and any Covered Person or to be consideration for, or an inducement or condition of, the employment of any employee. Nothing in these documents shall be deemed to give any Employee the right to be retained in the service of the Plan Sponsor or to interfere with the right of the Plan Sponsor to discharge any Employee at any time.

**AMENDMENTS TO OR TERMINATION OF PLAN:** The right is reserved in the Plan for the Plan Sponsor to terminate, suspend, withdraw, amend or modify the Plan, covering any Employee, in whole or in part at any time. Any such change or termination in benefits (a) will be based solely on the decision of the Plan Sponsor and (b) may apply to all Covered Employees, as either separate groups or as one group. This is subject to the applicable provisions of the Plan. In the event of any amendment which adversely affects any rights described in booklets issued under the Plan, new booklets or amendments showing the change will be issued.
GENERAL PROVISIONS (continued)

EXPLANATION OF PLAN BENEFITS: An oral explanation of any benefits of the Plan by an employee of the Plan Sponsor, its representative or agent, which disagrees with the provisions of the Plan shall not be legally binding.

PRONOUNS: Masculine pronouns used in the SPD will apply equally to both male and female persons.

WORKER’S COMPENSATION: The Plan is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

DENTIST-PATIENT RELATIONSHIP: The Covered Person will have free choice of any Dentist. The Plan Sponsor will in no way disturb the Dentist-Patient relationship. In addition, the Plan is not responsible for any Injuries or damage a Covered Person or a Covered Dependent may suffer due to the actions of any medical or dental provider.

FEDERAL LAWS: The Plan shall comply with all Federal mandated benefits, laws and regulations as they pertain to employee benefit plans, including without limitations the Americans with Disability Act of 1990 and Family and Medical Leave Act of 1993.

GENERAL DEFINITIONS

ACTIVE SERVICE: A Covered Employee will be considered in Active Service on a day which is a scheduled work day if he/she is performing in the customary manner all of the regular duties of his/her employment or at some location at which that employment requires him/her to travel. A Covered Employee will be considered in Active Service on the day which is not a scheduled work day only if he/she was performing in the customary manner all of the regular duties of his/her employment on the last preceding work day.

CALENDAR YEAR: Means a period of 12 consecutive months ending on any December 31st.

COVERED DEPENDENT: Means a Dependent of any Covered Employee for whom coverage became effective and has not terminated.

COVERED EMPLOYEE: Means an Eligible Employee whose coverage under the Plan became effective and has not terminated.

COVERED PERSON: Means either a Covered Employee or a Covered Dependent.

DENTIST: Means a practitioner of the healing arts who is duly licensed in the state where he/she is practicing and who is treating within the scope and limitation of that license. The term Dentist will not include the Covered Employee, nor his spouse, children, brothers, sisters, or parents; nor any person residing in his household; nor any of the preceding of the Covered Employee's spouse.

DEPENDENT: Means the lawful spouse of the opposite sex and each unmarried child of the Covered Person who is not a Covered Employee nor on full-time active duty in the military service of any country. A Covered Employee's Dependent Children shall include the following, provided they meet the definition of a qualifying relative under Section 152 of the Internal Revenue Code of 1986, except the gross income test does not apply for coverage under the Plan as amended:
GENERAL DEFINITIONS (continued)

DEPENDENT (continued):

1. Unmarried natural children and legally adopted children who rely on the Covered Employee for support and are less than 19 years old; unmarried step-children or unmarried children for whom the Covered Employee is the legal guardian who rely on the Covered Employee for support and are less than 19 years old.

2. Unmarried children (as defined above) who rely on the Covered Employee for over one-half of their financial support, are 19 years old, but less than 26 years old, and who attend an accredited school or college on a full-time basis and are not regularly employed by one or more employers on a full-time basis of 30 or more hours per week exclusive of scheduled vacation periods. An accredited school or college means a secondary school which is accredited by the state board of education; or a junior college, college or university accredited by a nationally recognized educational organization.

3. If a Dependent Child, while covered under this Plan, should become incapable of self-sustaining employment, due to mental retardation or physical handicap prior to reaching the age of 19 years, he/she may continue to be considered a Dependent under the Plan. However, the Covered Employee must notify the Plan Sponsor of this incapacity (in writing) within 31 days after the child reaches age 19 and proof of the incapacity must be furnished as required by the Plan Sponsor but not more often than once a year. This Dependent must otherwise qualify as a Dependent to be continued for coverage.

EXPENSES INCURRED: An expense will be considered to be incurred at the time the service or the supply to which it relates is provided. The Preparation Date will be considered the date incurred for the placement of a Prosthesis. The date surgery is performed for an Implant(s) will be considered the incurred date for the placement of the Prosthesis on the Implant(s).

IMMEDIATE FAMILY: Means the Covered Employee's spouse, children, brothers, sisters, parents and any of the preceding of the Covered Employee's spouse.

PLAN CHANGES: Any increase or decrease of covered expenses due to a Plan change shall be in accordance with the date the expense is incurred.

PREPARATION DATE: Means the date of the removal of decayed or damaged portion of the tooth and shaping the remaining tooth structure to receive and retain the restorative material, which includes a Prosthesis.

PROSTHESIS: An artificial replacement that covers one or more natural teeth or the area where one or more natural teeth are missing. This would include crowns, onlays, inlays, dentures, bridgework and veneers.

TYPES OF COVERAGE:
Employee Coverage (Male or Female) - Coverage is provided for the Employee only.
Family Coverage - Coverage is provided for the Employee, Spouse and all Dependent Children.
Split Family Coverage - When husband and wife are both Covered Employees under the Plan, one, but not both, may cover Dependent Children at a reduced cost.
CLAIMS REIMBURSEMENT PROVISIONS

NOTICE: A completed dental reimbursement claim form must be submitted along with a paid receipt from the dentist. The dental reimbursement claim forms are available at the main office of each school or at the Guilford County Schools Benefits Office.

PAID RECEIPT: A paid receipt from the dentist is required before reimbursement may be determined by the Plan. The receipt from the dentist must show the following:
   a. Name of the patient;
   b. Date(s) the services were rendered;
   c. Type(s) of treatment performed; and
   d. Date(s) and Amount(s) of payment.

False bills or documents submitted for reimbursement will be considered a fraudulent act and will be grounds for immediate disciplinary action, up to and including dismissal.

Dental Benefit payments are not assignable and reimbursement payments for eligible expenses will be made directly to the Covered Employee or Covered Person under Federal Continuation Coverage (PHSA).

MINIMUM PAYMENT: The Plan will allow the submission of up to five reimbursement requests for payments related to Covered Dental Expenses incurred on the same date, subject to a minimum payment of at least $100.00, or payment in full. All payments for Covered Dental Expenses must be received within the Time Limitations provision, otherwise reimbursement will be denied.

TIME LIMITATIONS: Claims for dental reimbursement must be submitted no later than twelve months after the date Covered Dental Expenses are incurred. This will include any requested information to verify a claim is reimbursable under the Plan.

COORDINATION OF BENEFITS

APPLICATION: If any Covered Person under this Plan (which, for purposes of this section of the SPD, includes this Plan and any other group dental care expense benefits provided through or by the Plan Sponsor) is also covered under one or more Other Plans, the benefits payable with respect to him/her under this Plan will be coordinated with benefits payable with respect to him/her under all Other Plans. Coordination will apply in determining the benefits payable with respect to a Covered Person for any Claim Determination Period if, for the Allowable Expenses incurred during that Period, the sum of:
   1. The benefits that would be payable under this Plan in the absence of coordination, and
   2. The benefits that would be payable under all Other Plans in the absence of provisions for coordination in those Other Plans,
would exceed those Allowable Expenses.

Except as provided in the following paragraph, when coordination of benefits applies to the benefits payable with respect to a Covered Person for a Claim Determination Period, the benefits that would be payable for Allowable Expenses incurred during that Period under this Plan, in the absence of coordination of benefits, will be reduced to the extent necessary so the sum of those reduced benefits and all the benefits payable for those Allowable Expenses under all Other Plans will not exceed the total of those Allowable Expenses. Benefits payable under all Other Plans include the benefits that would have been payable had claims been properly made for them.
COORDINATION OF BENEFITS (continued)

APPLICATION (continued):

If, in coordinating the benefits of this Plan with those of any Other Plan, the rules set forth in the following paragraph would require this Plan to determine its benefits before the Other Plan and the Other Plan, which contains a provision coordinating its benefits with those of this Plan, would according to its rules determine its benefits after the benefits of this Plan have been determined, then the benefits of the Other Plan will be ignored for the purposes of determining the benefits of this Plan.

ORDER OF BENEFIT DETERMINATION: The rules establishing the order of benefit determination are:

1. A plan which does not provide for coordination of benefits will pay its benefits first;
2. A plan which covers a person other than as a dependent will pay its benefits before the plan which covers the person as a dependent;
3. A plan which covers a person other than as a laid-off or formerly employed person, or as a dependent of such person, will pay its benefits before the plan which covers the person as a laid-off or formerly employed person, or as a dependent of such person;
4. When a child is covered by the plans of both parents, unless they are divorced or legally separated, the plan of the parent whose birthday occurs earlier in the Calendar Year, regardless of the year of birth, will pay first. When both parents have the same birthday, the plan that has covered the child for the longest period of time will pay first;
5. If a child’s parents are divorced or legally separated, payment will be made:
   a. Under the plan of the parent with custody before the plan of a step-parent or of the parent without custody; or
   b. Under the plan of a step-parent before the plan of the parent without custody.

   However, if, by court decree, one parent is held responsible for the child’s dental care expenses, payment will be made first under the plan of that parent; and
6. When the rules above do not apply, the plan which has covered the person for the longer period of time will pay its benefits first. A new plan is not established when coverage by one carrier is replaced within one day by that of another.

When coordination of benefits operates to reduce the total amount of benefits otherwise payable during any Claim Determination Period with respect to a Covered Person covered under this Plan, each benefit that would be payable in the absence of coordination of benefits will be reduced proportionately, and the reduced amount will be charged against any applicable benefit limit of this Plan.

RELEASE OF INFORMATION: For the purpose of determining the applicability of and implementing the terms of the above provisions of the Plan or any similar provision of another plan, the Plan Administrator may, without the consent of or notice to any Covered Person, release to or obtain from an insurance company or other organization or individual any information, concerning any Covered Person, which the Plan Administrator considers to be necessary for those purposes. Any Covered Person claiming benefits under this Plan will furnish to the Plan Administrator such information as may be necessary to implement the above provisions.
COORDINATION OF BENEFITS (continued)

**RECOVERY:** At any time, when payments have been made by the Plan for Allowable Expenses in a total amount in excess of the maximum amount of payment necessary at that time to satisfy the intent of the above provisions, the Plan will have the right to recover these payments, to the extent of the excess, from among one or more of the following, as the Plan Administrator will determine: Any Covered Persons to or for with respect to whom these payments were made, any other insurance company, or other organizations.

**OTHER PLAN:** means any of the following types of coverage providing dental benefits or services:

1. Group, blanket or franchise insurance coverage;
2. Any group dental service prepayment, group practice or other group prepayment coverage;
3. Group coverage under labor-management trusteed plans, union welfare plans, employer organization plans or employee benefit plans;
4. Coverage under governmental programs or coverage required or provided by any statute; and
5. Coverage provided through a school or educational institution.

For purposes of the coordination of benefits provision, Other Plan does not include:

1. School accident insurance plans covering grammar and high school students;
2. Individual dental insurance policies for which the individual or an insured Dependent makes premium payments directly to the organization providing coverage; or
3. Medicaid (Title XIX, Grants to States for Medical Assistance Programs).

Other Plan will be construed separately with respect to each policy, contract or other arrangement for benefits or services, separately with respect to that portion of a policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits, and separately with respect to that portion which does not reserve the right.

**ALLOWABLE EXPENSE:** means any necessary, reasonable and customary item of expense, at least a portion of which is covered under at least one of the plans covering the Covered Person for whom claim is made.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered to be both an Allowable Expense and a benefit paid.

**CLAIM DETERMINATION PERIOD:** means a Calendar Year beginning with any January 1st and ending with the next December 31st, except that the first Calendar Year of any Covered Person will begin with the effective date of coverage on his/her account under this Plan and end on the next December 31st.
While the benefits provided under the Plan are designed to reimburse a Covered Person for Covered Dental Expenses. The Plan shall not be responsible for payment of any Covered Dental Expenses arising from any injury or sickness suffered by a Covered Person if a third party or organization may be responsible for the injury or sickness. It is the intention of the Plan Sponsor that the Plan will only advance those Covered Dental Expenses for a Covered Person with the understanding and expectation that the Plan will be repaid in full through the Plan’s subrogation and reimbursement rights described in this section.

The Covered Person under the Plan is subject to two conditions that are designed to control rising dental care costs and the increased amount Covered Employees pay for coverage. First, if a Covered Person should be injured or suffer from a sickness for which a third party or organization may be liable or responsible, the Plan is automatically subrogated to all rights of recovery which a Covered Person may have against such third party or organization for the full amount of any benefits the Plan pays. This means that the Plan may use a Covered Person’s right to recover money from the other party or organization (including any insurance company insuring such third party or organization) to the extent of the benefits the Plan may have reimbursed a Covered Person.

Second, in addition to the Plan’s right of subrogation, if a Covered Person actually recovers money from a third party or organization (including an insurance company insuring such third party or organization) for any injury or sickness for which benefits have been provided under the Plan, the Covered Person is required to reimburse the Plan first from the amount recovered for 100% of the amount of benefits the Plan has reimbursed the Covered Person. This means that a Covered Person immediately must pay to the Plan the amount of money recovered by the Covered Person through judgment or settlement from the third party or organization (including an insurance company insuring such third person or organization), up to the amount of benefits paid or provided by the Plan.

The Plan’s rights of subrogation and reimbursement may be from, by way of illustration and not limitation, monies received from the third party, any liability or other insurance covering the third party, and/or the Covered Person’s own uninsured motorist insurance, underinsured motorist insurance, or no fault insurance coverages.

The Plan’s rights come first, even if:

1. A Covered Person does not receive from the third party or organization (or any insurance company insuring such third party or organization) all of the damages a Covered Person claims to have suffered;
2. The payment a Covered Person receives is for, or described as for, a Covered Person’s damages (such as for personal injuries or pain and suffering) other than dental care expenses;
3. The Covered Dependent recovering the money is a minor; or
4. The Covered Person is deceased.

This means that all amounts received by a Covered Person will be subject to subrogation and reimbursement, even if the Covered Person does not receive full compensation for all of his/her losses and expenses.
The Covered Person must fully assist and cooperate with the Plan Administrator in protecting the subrogation and reimbursement rights of the Plan and must do nothing that would interfere with or diminish those rights. A Covered Person is required to furnish to the Plan Administrator promptly all information they have concerning a Covered Person’s rights of recovery or recoveries from other parties or organizations. Before the Plan will reimburse any Covered Dental Expenses to a Covered Person, an acknowledgment of subrogation and reimbursement rights form must be completed and signed by the Covered Person and submitted to the Plan Administrator. The Plan is entitled to enforce its subrogation and reimbursement rights even if the Covered Person did not submit a completed acknowledgment of subrogation and reimbursement rights form.

A Covered Person’s attorney must notify the Plan Administrator before filing any suit or settling any claim so as to enable the Plan Administrator to participate in the suit or settlement to protect and enforce the Plan’s rights. If a Covered Person does notify the Plan Administrator so that the Plan is able to and does recover the full amount of the benefits reimbursed by the Plan to a Covered Person, the Plan will share proportionately with the Covered Person in any attorney’s fees charged a Covered Person by an attorney for obtaining the recovery. If a Covered Person does not give the Plan Administrator such notice, the Plan’s reimbursement or subrogation recovery will not be decreased by any attorney’s fees for the Covered Person’s attorney. The Covered Person acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines and agrees to retain only an attorney who will not assert those doctrines.

**THE PLAN ADMINISTRATOR, IN ITS SOLE DISCRETION, MAY WITHHOLD, SUSPEND OR TERMINATE THE REIMBURSEMENT OF ANY BENEFITS, OR THE PROVISION OF ANY FUTURE BENEFITS, FOR A COVERED PERSON IN ORDER TO PROTECT THE SUBROGATION AND REIMBURSEMENT RIGHTS OF THE PLAN.**

The Covered Person must understand that the purpose of the Plan’s subrogation and reimbursement rights is not to penalize a Covered Person who may suffer an injury or sickness for which a third party or organization may be responsible. Instead, these rights help the Plan Sponsor control dental care costs under the Plan and lessen the need to increase the amount paid for coverage by and/or for Covered Employees and their Covered Dependents.

If the Plan must bring an action against a Covered Person to enforce this provision, then that Covered Person agrees to pay the Plan’s attorney’s fees and costs, regardless of the action’s outcome.