Summary Plan Description and Plan Document

This Summary Plan Description explains in detail how the Plan works. However, if you have any questions concerning your benefits, ask your employer or benefits representative for more details.

Some employers are subject to ERISA. Under ERISA, the information contained in this document is provided to comply with ERISA, which is the Employee Retirement Income Security Act of 1974, As Amended. If your employer is not subject to ERISA, this document provides valuable information about your plan for informational purposes only.

Employer, Plan Sponsor, Plan Administrator, and agent in the event of legal action involving the Plan: WARE COUNTY SCHOOLS
Address: 1301 Bailey Street, Waycross, GA 31501
Name of Plan: Dental Plans
Group Number: #S46
Claims Processor: 90 Degree Benefits, 2810 Premiere Pkwy, Ste. 400, Duluth, GA 30097
Dependent Age Limit: Age 26
Plan Year: January 1 thru December 31
Coverage begins: 1st of month following 30 days of employment
Coverage classes available:
Individual Coverage (Employee/Retiree) which covers only you
Family Coverage – which covers you and all your dependents

Benefit Amounts Paid by the Plan:
The Plan Year in which the treatment is provided is the year used to determine the reimbursement.

*The **Premium Dental Plan** will pay for benefits for each covered person as follows:*
100% of the first $300 of expenses, then
50% of the next $4,400 of expenses.
Maximum Plan Year Benefit of $2,500 per person.
Orthodontics for adults and children is covered under plan above

*The **Standard Dental Plan** will pay for benefits for each covered person as follows:*
100% of the first $250 of expenses, then
50% of the next $3,000 of expenses.
Maximum Plan Year Benefit of $1,750 per person.
Orthodontics for adults and children is NOT covered.

Reduced Benefits for Late Enrollment:
- A Late Entrant is anyone who reenrolls in the Plan after first decline to participate, regardless of whether the enrollment is at the beginning of any plan year or not.
- If you (or your dependents) are late entrants, the amount of expenses that will be reimbursed is reduced for the first Plan Year in which you (or your dependents) participate in the Plan.

- After the first Plan Year during which you (or your dependents) participate as late entrants, you (or your dependents) will be eligible for standard plan benefits, assuming you (or your dependents) continue to participate in the Plan.
- If you (or your dependents) subsequently drop coverage during an annual enrollment period and then re-enroll during a following annual enrollment period, the amount of expenses that will be reimbursed is again reduced for the first Plan Year in which you (or your dependents) resume participation in the Plan.
- An individual who first declines coverage and subsequently enrolls must be a Late Entrant before receiving full benefits in the next subsequent full Plan Year.

The **Late Entrant Premium Dental Plan** will pay for benefits for each covered person as follows:

- 50% of the $2,000 of expenses up to an annual maximum of $1,000

The Late Entrant Standard Dental Plan will pay for benefits for each covered person as follows:

- 50% of $1,500 of expenses up to an annual maximum of $750.

The ***Retiree Premium Dental Plan*** will pay for benefits for each covered person as follow:
100$ of the first $250 of expenses, then
50% of the next $2,500 of expenses
Maximum Plan Year Benefits of $1,750 per covered person
Orthodontics for adults and children is covered under plan above

The ***Retiree Standard Dental Plan*** will pay for benefits for each covered person as follow:
100$ of the first $200 of expenses, then
50% of the next $1,600 of expenses
Maximum Plan Year Benefits of $1,250 per covered person
Orthodontics for adults and children is NOT covered

The Plan is a self-funded, uninsured benefit plan that reimburses eligible employees and their eligible dependents for covered dental expenses.

- The Claims Processor processes claim payments on the behalf of the Employer. The employer funds the claims account.
- If the claims account has insufficient funds to pay processed claim, claim checks cannot be released.
- The Plan is available to the employees of Employer and its affiliates that participate in the Plan.
- The Plan does not involve an insurance company.
- As a self-funded plan, it is not regulated by state insurance laws. The plan is subject to federal rules and laws, such as ERISA, COBRA, HIPAA/Section 125.

- If you elect to participate in the Plan, your pay will be reduced so that your premium is paid on a pre-tax basis. You can have the premium paid on an after-tax basis if you state this in writing to the Plan Administrator.
- You may elect to cover only yourself or you may elect to cover yourself and your eligible dependents. You cannot elect coverage for your dependents only. If two spouses work for the employer only one can elect dependent coverage.
- As you incur expenses—as you "have a claim", you may submit these claims for reimbursement to the Claims Processor.
- If your expenses are eligible for reimbursement under the terms of the Plan, you will receive a check for all or a portion of the reimbursable expenses, according to the plan benefits.
- The Employer reserves the right to amend or terminate this Plan at any time.
- Nothing in this Summary Plan Description shall imply that benefits are vested or cannot be changed. The Employer can also change the benefits or contributions under the Plan or any other aspect of the Plan at any time and for any reason. The changes can apply to all covered persons. These amendments will normally not affect expenses incurred prior to the date of enactment of the amendments.

Persons Eligible to Receive Coverage:

Employees:

- All full-time employees who have met the required waiting period, and qualified retires, and their eligible dependents, may participate in the Plan.
- You are a full-time employee if you routinely work at least 20 hours per week.

Dependents:

- Eligible dependents include your spouse and children less than 26 years of age.
- Eligible children's coverage ends at the end of their 26th birthday month.

Handicapped children:

An unmarried child with a mental or physical handicap or developmental disability, who can't support himself/herself, may stay eligible for dependent coverage beyond the Plan's age limit if,

a) The condition started before he/she reached this Plan's age limit for eligibility.
b) He/she depends on you for most of his/her support and maintenance. To do this, it is the employee's responsibility to send written proof that the child is handicapped and depends on you for most of his/her support and maintenance within 31 days from the date the child reaches the age limit.

The employer may be asked for periodic proof that the child's condition continues. The child's coverage ends when yours does.

Retirees:

- If a retiree deceases, the spouse and/or child(ren) may retain Retiree Status on a separate retiree plan.

Coverage for you and your dependents/family:
You can elect one of the coverage classes shown on Page 1.

Special Rules for a Divorce:

- If you are divorced or separated from your spouse, you may be required under the terms of a "Qualified Medical Child Support Order" to provide coverage under the Plan to any of your children named in such order.
- A Qualified Medical Child Support Order ("QMCSO") is an order satisfying the requirements of ERISA and requiring a health plan to recognize the child of a parent-employee as a plan participant.
- If the Plan Administrator receives a QMCSO for an employee who is not presently enrolled in the Plan, then the employee will need to be enrolled in the plan and the child(ren) will be added as dependents.

Cost of Coverage:

- You must pay the amounts requested by the Employer, if any, for you or your dependents to be covered.
- You will be told the exact amount at the time of enrollment.
- The Plan is self-funded, meaning that no insurance protection is available. If claims are higher than projected, the Plan Administrator may have to increase the costs that you pay for this Plan, at any time.

Enrolling for Coverage:

- Prior to the first day of each Plan Year, the Company will provide an annual enrollment period during which you may elect coverage under the Plan.
- If you already have coverage, you can change the type of coverage (for example, from individual to family coverage). The coverage that you elect during the annual enrollment period will become effective on the first day of your plan year following the annual enrollment period.
- If you do not make changes during the annual enrollment period, you will continue with same election you made for the prior year, although benefits and costs may change.
- If you become employed during the Plan Year and you elect coverage during a period other than the open enrollment period, your coverage will be effective on the date specified by your Employer.
- In the event that an employee is also a dependent of another covered employee, the employee can elect to be covered only once—either as the employee or as the dependent.

Changing the coverage election or change of family status:

- Your election to receive coverage under the Plan will remain in effect for the Plan Year.
- If you are a new employee and elect coverage during a period other than the open enrollment period, your initial election will remain in effect from the date your election became effective until the end of the Plan Year.
- If you do not complete a new election form for coverage during the next annual enrollment period, your election automatically will remain in effect for the next Plan Year.
- You may change or revoke your election during the Plan Year only if you experience a "change in family status", and the change in coverage is on account of and consistent with the change in family status.

Examples of changes in family status include:

1. Your marriage, divorce or legal separation;
2. The birth or adoption of a child;
3. The death of a dependent;
4. A dependent that either becomes eligible for coverage or is no longer eligible;
5. A change in your spouse's employment;
6. The receipt of a qualified medical child support order;
7. A “special enrollment period,” as required under the Internal Revenue Code; or
8. Any other event deemed a change in family status by the Plan Administrator, in accordance with applicable law.

Late Enrollment:

- If you (or your dependents do not enroll in the Plan when you (or your dependents) first become eligible to participate in the Plan, you may enroll yourself (or your dependents) during the annual enrollment period for the next Plan Year or a later Plan Year.
- If you (or your dependents) do not enroll in the Plan when you (or your dependents) first become eligible to participate, you (or your dependents) will be referred to as a “late entrant”. (late entrants are subject to reduced benefits under the Plan, as described on pages 1 and 2.

Expenses Covered:

- You will be reimbursed for all properly submitted covered expenses incurred by you or your covered dependents while you are covered under the Plan, except for those expenses discussed below that are not covered under the terms of the Plan.
- Covered expenses include treatment by any licensed dental provider.

Expenses Not Covered:

- Expenses incurred for injuries or conditions, which are payable through workers' compensation;
- Expenses incurred for orthodontic procedures, unless specifically stated in this document;

- Expenses incurred for cosmetic procedures to include, but not necessarily limited to, cosmetic veneers and bleaching. The Plan Administrator determines what claims are considered cosmetic, based on industry consensus.

Claim Filing:

- When you or a covered dependent incur expenses, submit a claim form signed by the provider that describes the dates of service, the type of treatment and the charge. Properly completed claim forms should be sent directly to the Claims Processor by Fax, Email or Direct Mail. In the event that the provider cannot submit a claim form, submit receipts yourself for reimbursement. Each receipt must be mailed one-receipt per envelope, fax or email transmittal. The Claim Processor is not responsible for sorting and organizing receipts.
- The Claim Processor reserves the right to confirm expenses or request the original receipt prior to reimbursing any claim.
- Failure to present the original claim as request and when requested may result in a total denial of any claim.
- A fraudulent claim is grounds for termination of benefits and criminal prosecution determined within the sole discretion of the employer.
- Claim payment will be made within 30 days by the Claim Processor. If the claim cannot be paid in 30 days, the Claim Processor will provide notification of why the claim cannot be paid.
- All claims for expenses must be submitted no later than 90 days after the end of the Plan Year in which the expenses were incurred.

Coordination of Benefits (COB)

Coordination of Benefits ("COB") applies when a Covered Person has dental coverage under more than one benefit plan. "Other Plan" is defined below. The intent is that not more than 100% of the Allowable Expense is paid from the total benefits available between all benefit plans. Under this provision, the benefits of this Dental Plan may be reduced so that they and the benefits payable under the Other Plans do not total more than those Allowable Expenses.

- If this COB provision applies, the order of benefit determination rules (set forth below) will be applied to determine benefits under this Dental Plan. Those rules determine whether the benefits of this Dental Plan are determined before or after those of another Plan.
- Primary Plan/Secondary Plan. The order of benefit determination rules state whether this Dental Plan is a Primary Plan or Secondary Plan to another Plan covering the Covered Person.
  (i) When this Dental Plan is a Primary Plan, its benefits shall not be reduced, and are determined before those of the Other Plan and without considering the Other Plan's benefits.

(ii) When this Dental Plan is a Secondary Plan, its benefits are determined after those of the Other Plan and may be reduced because of the Other Plan's benefits.

- Allowable Expense means a necessary, reasonable, and customary item of expense for healthcare, when the item of expense is covered at least in part by one or more Other Plans covering the Covered Person for whom the claim is made.
- Other Plan means any of the following which provide benefits or services for, or because of, dental care or treatment:
  (i) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, individual practice coverage. It also includes coverage other than school accident-type coverage.
  (ii) Coverage under a governmental plan or coverage that is required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to states for Medical Assistance Programs, or the United States Social Security Act, as amended from time to time). It also does not include any plan whose benefits, by law, are excess to those of any private insurance or other non-governmental program.
- Order of Benefit Determination Rules. This Dental Plan determines its order of benefits using the first of the following rules which applies:
  (i) Non-Dependent/Dependent. The benefits of the plan which covers the Covered Person as an employee or dependent (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent.
  (ii) Dependent Child/Parents Not Separated or Divorced. Except as stated in subparagraph (3), when this Dental Plan and the Other Plan cover the same child as a dependent of different persons, called "parents":
    1) The benefits of the plan of the parent whose birthday falls earlier in the calendar year are determined before those of the plan of the parent whose birthday falls later in the calendar year; but
    2) If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time.
    3) However, if the Other Plan does not have the birthday rule described above but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the Other Plan will determine the order of benefits.
  (iii) Dependent Child/Separated or Divorced Parents. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
    1) First, the plan of the parent with custody of the child.
    2) Then, the plan of the spouse of the parent with custody of the child.
    3) Finally, the plan of the parent not having custody of the child.
    4) However, if the specific terms of a court decree state that one of the parents is responsible for the healthcare expenses of the child, and

the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(iv) Active/Inactive Employee. The benefits of a plan that covers a person as an employee, who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule (4) is ignored.

(v) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan that covered the Covered Person longer are determined before those of the plan that covered that Covered Person for the shorter time.

Recourse for Denied Claims:

- If a claim is denied (all or in part), you will be informed of the reason(s) for denial, and you may initiate a review of the claim by contacting the Plan Administrator for further instructions.
- Under the review procedure, you or your duly authorized representative have the right to: (a) request the review by making written application to the Plan Administrator, no later than 60 days after the claim denial, (b) review pertinent Plan documents, and (c) submit issues and comments in writing in support of the claim.
- You will be notified in writing of the results of the claim review and the reason for any denial no later than 60 days following receipt of the properly completed request for review, unless it is necessary to seek additional information, in which case the determination will be made within 20 days of receiving the additional information.
- Any requests for review not responded to within this period shall be deemed denied.

Termination of Coverage:

Coverage for you, as well as that of your dependents, ends on the earliest of the following dates, subject to your right to elect COBRA coverage:

- The date this Plan is terminated by the Employer or by Simple;
- The date this plan is amended to exclude you or your dependents from the class of employees or dependents, as applicable, eligible for coverage;
- The date you are no longer in an eligible class of employees or, with respect to a dependent's coverage, the date the dependent is no longer an eligible dependent;
- The last day of the month in which your employment ends;
- The last day of the month for which the last required contribution was made, by or on behalf of, the Covered Person.

- The date of your death; or
- The date you withdraw from the Plan.
- If you take a leave of absence pursuant to the Family and Medical Leave Act, ("FMLA"), your elected coverage will be continued by the Company for the authorized period of leave. You will have to pay the premium for your coverage while on leave.

Your Rights Under COBRA:
As described below, and in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1986, as amended (COBRA), Covered Persons may be able to continue their coverage under this Plan.

Length of COBRA:
A Covered Person may elect to continue coverage under this Plan for up to 18 months if his coverage terminates because:

1. The covered Employee's employment is terminated (for reasons other than the gross misconduct); or
2. The covered Employee's number of hours of employment is reduced such that he is no longer eligible for coverage under this Plan.
    - The 18 months of continuation coverage may be extended to 29 months if the Social Security Administration determines, according to Title II or XVI of the Social Security Act, that a Covered Person was disabled during the first 60 days of continuation coverage, or for a child born to or placed for adoption with a Covered Person during the continuation coverage period, during the first 60 days of birth or adoption.
    - All Covered Persons with respect to the disabled individual who would otherwise lose coverage are entitled to the extension.
    - It is the Covered Person's responsibility to obtain this disability determination from the Social Security Administration and the responsibility of any of the Covered Persons to provide a copy of the determination letter to the Plan Administrator within 60 days of the date of determination and before the original 18 months of continuation coverage ceases.
    - If there is a final determination that the Covered Person is no longer disabled, the Plan Administrator must be notified within 30 days of the determination by the Covered Person, and any coverage extended beyond the maximum that would otherwise apply will be terminated for all qualified beneficiaries.
    - A covered Dependent may elect to continue coverage under this Plan for up to 36 months, if such Dependent's coverage terminates because:

        1. The covered Employee dies;
        2. The covered Employee is divorced or legally separated;
        3. The covered Employee becomes entitled to Medicare benefits under Title XVIII of the Social Security Act;
        4. A child covered under the Plan ceases to be a Dependent.

NOTICE: The Covered Person must notify the Plan Administrator of a divorce or legal separation or when a child ceases to be a Dependent within 60 days of such event. Failure to do so will result in the loss of coverage under this Limited Continuation of Coverage provision. Upon notice that one of these events or another qualifying event has occurred, the Plan Administrator or its designee will notify the Covered Person of his Limited Continuation of Coverage rights.

Electing COBRA:
A Covered Person is entitled to an election period of 60 days in which to elect to continue coverage under the Plan. The 60-day election period begins on the date the Covered Person would lose Plan coverage because of one of the events described above, and ends on the later of 60 days following such date or the date the Covered Person is sent a notice about eligibility to elect to continue coverage.

If a Covered Person elects continuation coverage within the 60-day election period, continuation coverage will generally begin on the date regular Plan coverage ceases. Even if a Covered Person waives continuation coverage, but within the 60-day election period revokes the waiver, continuation coverage will also begin on the date regular Plan coverage ceases. A Covered Person may not revoke a waiver after the end of the 60-day election period.

If a Covered Person does not choose continuation coverage within the 60-day election period, eligibility for continuation coverage under the Plan ends at the end of that period.

Cost of COBRA Coverage:
To receive continuation coverage, the Covered Person must pay the required monthly premium plus a two percent administrative charge. If a Covered Person is determined to have been disabled under Title II or XVI of the Social Security Act at the time of the qualifying event of termination of employment or reduction of hours of employment, then the cost of continuation coverage will be 150 percent of the normal required monthly premium for all months after the 18th month of continuation coverage.

Each monthly premium for continuation coverage is due on the first day of the month for which coverage is being continued. However, the first such monthly premium is not due until 45 days after the date on which the Covered Person initially elects continuation coverage.

COBRA Regulations – 2010 Revisions:
The American Recovery and Reinvestment Act of 2009 (ARRA), as amended on March 2, 2010 by the Temporary Extension Act of 2010, provides for premium reductions for health benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly called COBRA. Eligible individuals pay only 35 percent of their COBRA premiums and the remaining 65 percent is reimbursed to the coverage provider through a tax credit.

To qualify, individuals must experience a COBRA qualifying event that is the involuntary termination of a covered employee's employment. The involuntary termination must generally occur during the period that began September 1, 2008 and ends on March 31, 2010. (An

involuntary termination of employment that occurs on or after March 2, 2010 but by March 31, 2010 and follows a qualifying event that was a reduction of hours that occurred at any time from September 1, 2008 through March 31, 2010 is also a qualifying event for purposes of ARRA.) The premium reduction applies to periods of health coverage that began on or after February 17, 2009 and lasts for up to 15 months.

Benefits Under COBRA:
If a Covered Person chooses continuation coverage, the coverage is identical to the coverage then being provided under the Plan to similarly situated employees, their spouses and their Dependent children who have not experienced a qualifying event. If their coverage changes, continuation coverage will change in the same way.

Claim Payment:
No claim will be payable under this Limited Continuation of Coverage provision until the Plan Administrator receives the applicable premium.

Termination of COBRA:
A Covered Person's Coverage under this Limited Continuation of Coverage provision will terminate on the earliest of:

1. The date on which the Company ceases to provide a group health plan to any employee;
2. The date the Covered Person first becomes covered under any other group health plan after electing continuation coverage, provided that applicable law precludes any preexisting condition exclusion in the new plan from affecting the Covered Person's coverage under the new plan;
3. The date the Covered Person becomes entitled to Medicare benefits under Title XVIII of the Social Security Act;
4. The date the required monthly premium is due, if the Covered Person fails to make payment within 30 days after the due date; or
5. The end of the applicable continuation coverage period described above.

In no case will coverage extend beyond thirty-six months from the original qualifying event, even if a second qualifying event occurs during the continuation coverage period.

Plan Funding:
Company and employee contributions cover the projected cost of the Plan. In the event the contributions are not able to cover the actual claims, the Plan may receive additional funds from the Employer and/or Employees, or the Plan may be terminated. Company contributions and any employee pre-tax contributions withheld by way of payroll deduction are held by the Company and used to pay Plan benefits. All employee contributions to the Plan shall be withheld from the employee's paycheck on a pre-tax basis unless the employee requests, in writing to the Plan Administrator, that the required contributions be withheld on an after-tax basis.

ERISA RIGHTS: If your employer is subject to ERISA, as a participant in the Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the plan.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan and an updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that the plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.