DENTAL BENEFIT WITH ORTHODONTICS

For

LAURENS COUNTY BOC

Administered By

BlueCross BlueShield of Georgia

Si usted necesita ayuda en español para entender este documento, puede solicitarla gratuitamente llamando a Servicios al Cliente al número que se encuentra en su tarjeta de identificación.

If You need assistance in Spanish to understand this document, You may request it for free by calling Member Services at the number on Your identification card.

ASODNHIAA 2017

This Benefit Booklet provides You with a description of Your benefits while You are enrolled under the **dental** care plan (the "Plan") offered by Your Employer. You should read this booklet carefully to familiarize yourself with the Plan's main provisions and keep it handy for reference. A thorough understanding of Your coverage will enable You to use Your benefits wisely. If You have any questions about the benefits as presented in this Benefit Booklet, please contact Your Employer's Group Dental Plan Administrator or call the Claims Administrator's Member Services Department.

The Plan provides the benefits described in this Benefit Booklet only for eligible Members. The dental care services are subject to the limitations, exclusions, Deductible, and Coinsurance requirements specified in this Benefit Booklet. Any group plan or certificate which You received previously will be replaced by this Plan.

Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. or "BCBSGA has been designated by Your Employer to provide administrative services for the Employer's Group Dental Plan, such as claims processing, case management, and other services, and to arrange for a network of dental care *providers* whose services are covered by the Plan.

Important: This is not an insured benefit Plan. The benefits described in this Benefit Booklet or any rider or amendment attached hereto are funded by the Employer who is responsible for their payment***.BCBSGA provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims***.

BCBSGA is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, permitting BCBSGA to use the Blue Cross and Blue Shield Service Marks in portions of the State of Georgia. BCBSGA has entered into a contract with the Employer on its own behalf and not as the agent of the Association.

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Schedule of Benefits	
All payments are based on Covered Expense.	
Yearly Maximum Maximum per calendar year per Member based on Covered Expense	$1,000
Calendar Year Deductible Individual Deductible Amount Family Deductible The first three Members of an enrolled family to satisfy their Deductible will satisfy the Deductible for the entire family.	$50 $150
Orthodontic Services Lifetime Maximum Benefit per Member under age 19	$1,500
Percentage Payable All payments are based on Covered Expense.	
Type 1 – Preventive Participating Provider (not subject to Deductible) Non-Participating Provider (not subject to Deductible)	 100% 100%
Type 2 – Basic Participating Provider Non-Participating Provider	 80% 80%
Type 3 – Major Participating Provider Non-Participating Provider	 50% 50%
Type 4 – Orthodontic Participating Provider Non-Participating Provider	 50% 50%

Eligibility

Members who do not enroll within 31 days of being eligible are considered Late Enrollees. Please refer to the "Late Enrollees" provision in this section.

Coverage for the Employee

This Benefit Booklet describes the benefits an Employee may receive under this dental care Plan. The Employee is also called a Subscriber.

Coverage for the Employee's Dependents

If the Employee is covered by this Plan, the Employee may enroll his or her eligible Dependents. Covered Dependents are also called Members.

Eligible Dependents Include:

- The Employee's Spouse.
- The Employee's dependent children at the end of the month they attain age 26, legally adopted children from the date the Employee assumes legal responsibility, children for whom the Employee assumes legal guardianship and stepchildren. Also included are the Employee's children (or children of the Employee's Spouse) for whom the Employee has legal responsibility resulting from a valid court decree.
- Children who are mentally or physically disabled and totally dependent on the Employee for support, past the age of 26 or older. To be eligible for continued coverage past the age of 26, certification of the disability is required within 31 days of attainment of age 26. A certification form is available from the Employer or from the Claims Administrator and may be required periodically. You must notify the Claims Administrator and/or the Employer if the Dependent's marital or tax exemption status changes and they are no longer eligible for continued coverage.

Initial Enrollees

Initial Enrollees and eligible Dependents who were previously enrolled under group coverage which this Plan replaces are eligible for coverage on the Effective Date of this coverage. Any Employer waiting period which was not satisfied under previous Creditable Coverage must be satisfied under this Plan. However, credit will be given for the length of time already served. Coverage will be effective based on the waiting period chosen by the Employer, and will not exceed 90 days.

New Hires

Applications for enrollment must be submitted within 31 days from the date an Employee is eligible to enroll as set by the Employer. Applications for membership may be obtained from the Employer. Coverage will be effective based on the waiting period chosen by the Employer and will not exceed 90 days. If the Employee or the Employee's Dependents do not enroll when first eligible, the Employee or the Employee's Dependents will be treated as Late Enrollees. Please refer to the "Late Enrollees" provision listed below.

Late Enrollees

If the Employee applies for coverage when first eligible, coverage will be effective on the date the Employer's length-of-service requirement has been met. The Effective Date of coverage is subject to any length-of-service provision the Employer requires and will not exceed 90 days.

Special Enrollment Periods

There are special enrollment periods for Employees or Dependents who:

- Originally declined coverage because of other coverage, and
- Exhausted COBRA benefits, lost eligibility for prior coverage, or Employer contributions toward coverage were terminated.

An individual who declined coverage must have certified in writing that he or she was covered by another dental plan when he or she initially declined coverage under this Plan in order to later qualify under this special enrollment. A person declining coverage will be given notice of the consequences when they originally decline coverage.

In addition, there are also special enrollment periods for new Dependents resulting from marriages, births or adoptions or placement for adoption. An unenrolled Member may enroll within 31 days of such a special qualifying event.

Important Notes:

- Individuals enrolled during special enrollment periods are **not** Late Enrollees.
- Individuals or Dependents must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).

Medicaid and CHIP Special Enrollment/Special Enrollees

Eligible Employees and Dependents may also enroll under two additional circumstances:

- the Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- the Employee or Dependent becomes eligible for a subsidy (state premium assistance program)

The Employee or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

When Coverage Begins

If the Employee applies for coverage when first eligible, coverage will be effective on the date the Employer's length-of-service requirement has been met. The Effective Date of coverage is subject to any length-of-service provision the Employer requires.

Changing Coverage

There may be an annual re-enrollment period during which time Members may elect to change their options. Employees and Dependents enrolled in another option may be required to complete an unfulfilled waiting period from a prior plan.

Types of Coverage

The types of coverage available to the Employee are indicated at the time of enrollment through the Employer.

Changing Coverage (Adding a Dependent)

You may add new Dependents to Your Plan by contacting Your Plan Administrator. The Plan Administrator must notify the Claims Administrator. The Plan Administrator is the person named by the Employer to manage the Plan and answer questions about Plan details.

Coverage is provided only for those Dependents the Employee has reported to the Plan Administrator and added to his or her coverage by completing the correct application.

Marriage and Stepchildren

An Employee may add a Spouse and eligible stepchildren within 31 days of the date of marriage by submitting a change-of-coverage form. The Effective Date will be the date of marriage.

If an Employee does not apply for coverage to add a Spouse and stepchildren within 31 days of the date of marriage, the Spouse and stepchildren are considered Late Enrollees. Please refer to the **"Late Enrollees"** provision in this section.

Newborn and Adopted Children
You must contact Your Employer within 31 days to add a newborn or adopted child.

OBRA 1993 and Qualified Medical Child Support Orders
The Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) provides specific rules for the coverage of adopted children and children subject to a Qualified Medical Child Support Order (QMCSO).
An eligible Dependent child includes:

- An adopted child, regardless of whether or not the adoption has become final.
  - An "adopted child" is any person under the age of 18 as of the date of adoption or placement for adoption. "Placement for adoption" means the assumption and retention by the Employee of the legal obligation for the total or partial support of a child to be adopted. Placement ends whenever the legal support obligation ends.
- A child for whom an Employee has received an MCSO (a "Medical Child Support Order") which has been determined by the Employer or Plan Administrator to be a Qualified Medical Child Support Order ("QMCSO").
  - Upon receipt of an MCSO, the Employer or Plan Administrator will inform the Employee and each affected child of its receipt of the order and will explain the procedures for determining if the order is a QMCSO. The Employer will subsequently notify the Employee and the child(ren) of the determination.

A QMCSO cannot require the Employer to provide any type or form of benefit that it is not already offering.

Family and Medical Leave
If a covered Employee ceases active employment due to an Employer-approved medical leave of absence, in accordance with the Family and Medical Leave Act of 1993 (FMLA), coverage will be continued for up to 12 weeks under the same terms and conditions which would have applied had the Employee continued in active employment. The Employee must pay his or her contribution share toward the cost of coverage, if any contribution is required.

Changing Coverage or Removing a Dependent
When any of the following events occur, notify the Employer and ask for appropriate forms to complete:

- Divorce;
- Death of an enrolled family member (a different type of coverage may be necessary);
- Dependent child reaches age 26 (see "When Coverage Terminates");
- Enrolled Dependent child becomes totally or permanently disabled.

Employee Not Actively at Work
Generally, if an Employee is not actively at work on the date his or her coverage is to be effective, the Effective Date will be postponed until the date the Employee returns to active status. If an Employee is not actively at work due to health status, this provision will not apply. An Employee is also a person still employed by the Employer but not currently active due to health status.

Covered Services

The Plan will pay for Covered Services you incur while covered under this Plan, subject to all terms, conditions, limitations and exclusions specified in this Benefit Booklet.

The Plan offers two important features. One is to assist you with expenses incurred for necessary dental care. The other is to encourage the use of preventive dental services by providing coverage for such services.

Covered Expenses
The **Schedule of Benefits** section shows the maximum payable benefit for Covered Services.

Participating Dentists have negotiated certain charges at the Negotiated Rate they will charge for Covered Services under this Plan. The Plan will pay the percentages listed in the Schedule of Benefits for Covered Services and you will be responsible for any difference up to the Negotiated Rate.

If you choose a **Non-Participating Dentist**, the Plan will pay the percentages listed in the **Schedule of Benefits** for Covered Services and you will be responsible for the amount that exceeds the Reasonable and Customary Charge. Therefore, your share of the costs for your care provided by a Non-Participating Dentist may be greater than if you choose a Participating Dentist.

Each Covered Expense is deemed to be incurred on the date the dental service or supply is provided, except that:

- for dentures and other similar appliances, the expense is deemed to be incurred on the date the master impression is made;
- for fixed bridges, crowns, inlay or onlay restoration, the expense is deemed to be incurred on the date a tooth is first prepared;
- for root canal therapy, the expense is deemed to be incurred on the date the pulp chamber is opened or a canal is explored to the apex; or
- for periodontal surgery, the expense is deemed to be incurred on the date the surgery is actually performed.

Extension of Benefits

If the Plan terminates, benefits will be continue for a period of 90 days for the following:

1. The installation of new appliances and modifications to appliances for which a master impression was made prior to the benefit termination date.
2. An installation of a crown, bridge, or cast restoration of which the tooth was prepared prior to the benefit termination date.
3. Root canal therapy, for which the pulp chamber was opened prior to the benefit termination date.

Dental Benefit

The coinsurance percentages shown in the **Schedule of Benefits** are payable for the Covered Expenses incurred from a Dentist for Medically Necessary dental services. Benefits are not payable for any Covered Expense which exceeds the Yearly Maximum benefits shown in the **Schedule of Benefits**.

Participating Dental Providers

All benefits payable are based on a Member's use of Participating or Non-Participating Providers.

BCBSGA will provide you with a directory of Participating Providers in your area from which you may choose. At all times, you and your Covered Dependents have a free choice of any dental care provider for any dental service or supply.

The **Schedule of Benefits** shows the benefit percentages payable for each type of Covered Expense incurred from Participating or Non-Participating Providers.

Change in Dental Benefits

If any dental coverage is revised, added or deleted, this change in coverage will not apply to dental services or supplies provided before the effective date of the change, if, before the date of the change, a treatment plan was received and benefits predetermined by BCBSGA.

Deductible

Before certain benefits are paid, you and your Dependents must satisfy the Deductible as stated in the **Schedule of Benefits**. This Deductible must be satisfied by each Member once a calendar year. However, if you and your covered family Members reach the Family Deductible Limit shown in the

Schedule of Benefits, then no further Deductible requirements will be applied for the balance of the calendar year.

There is a combined Deductible for Type 2 and Type 3 Services.

Special Requirements

- For new dental plans (non-replacement), Type 3 Services will not be covered for the first 12 months. Check with your employer to determine if this applies to your Group.
- For any late entrants to the program, Type 3 and Type 4 Services will not be covered for the first 12 months.

Type 1 - Preventive and Diagnostic Services

The Plan pays the percentage of Covered Expense shown in the **Schedule of Benefits** for the following services:

Prophylaxis

Two treatments are covered per calendar year. This includes cleaning, scaling and polishing of teeth to remove coronal plaque, calculus and stains. This service must be performed by a Dentist or by a licensed dental hygienist under the supervision of a Dentist.

Such services cannot exceed two per calendar year combined with those provided under Basic Services prophylaxis benefits.

Routine Oral Examinations

Two such examinations per Member per calendar year. This includes such procedures as case history, charting of existing restorations and defects, pocket probing, transillumination and mobility evaluation performed by a Dentist that aid in making diagnostic conclusions about the oral health of an individual patient and the dental care required. It also includes recall examinations (for review and recording of changes occurring since the last examination) and a treatment program if necessary.

Dental X-rays

Radiographs, full mouth X-rays or panoramic X-rays (not more than once in any period of 36 consecutive months). It also includes not more than two supplementary bitewing X-rays twice per calendar year and other dental X-rays as required in connection with the diagnosis of a specific condition requiring treatment.

Topical Application of Fluoride

Two treatments per calendar year for Members under age 15 only. The service must be performed by a Dentist or a licensed dental hygienist under the supervision of a Dentist.

Space Maintainers

Services to maintain existing space from the premature loss or extraction of deciduous teeth (primary or baby teeth) by means of a fixed or removable appliance designed to prevent adjacent and opposing teeth from moving. Adjustments are covered if required because of relative change in the condition of the mouth.

Diagnostic Casts

Pulp Vitality Testing (one per calendar year)

Sealants

For permanent teeth (limited to covered dependent children between the ages of 6 and 18 years old, once per tooth every 36 months).

Type 2 - Basic Services

After the calendar year Deductible is met, the Plan pays the percentage of Covered Expense shown in the **Schedule of Benefits** for the following services.

Simple Extractions

Fillings
Covers both silver amalgam and tooth colored synthetic materials.

Oral Surgery
Oral surgery procedures include surgical extractions of erupted teeth, alveoloplasty, frenulectomy, cyst and lesion removal, and treatment of fractures and dislocations.

Palliative Emergency Treatment
Covers one visit per occurrence.

Apicoectomy
Excision of the apex portion of a tooth root.

Occlusal Guards
Limited to one per lifetime.

Impactions
Surgical removal of impacted teeth.

Periodontic Services
This includes procedures to treat disease of the tissue and bone structures that support the teeth.

Periodontal Prophylaxis
Such services cannot exceed two per calendar year combined with those provided under the Preventive and Diagnostic prophylaxis benefits.

Endodontics
This includes procedures for the prevention and treatment of diseases of the dental pulp and surrounding periapical structures, such as pulpotomy, pulp capping and root canal treatments.

Gingivectomy and gingivoplasty

Osseous Surgery
Includes flap entry and closure.

Vestibuloplasty

Type 3 - Major Services

After the calendar year Deductible is met, the Plan pays the percentage of Covered Expense shown in the **Schedule of Benefits** for the following services.

Inlays

Crowns

Dentures
Includes both full and partial dentures.

Bridges
Fixed and removable bridges, except that:
- initial installation shall be limited to replacement of one or more natural teeth extracted while the Member is covered under this Plan, and
- the replacement or addition of teeth is required to replace one or more additional natural teeth extracted while covered under this Plan and after the existing denture or bridge was installed; or if
- the existing denture or bridge cannot be made serviceable.

Denture Rebase or Reline

Repair of Fixed Bridges

Repair of Removable Dentures

Re-cement crowns and bridges

Type 4 - Orthodontic Services

The Plan pays the percentage of Covered Expense shown in the **Schedule of Benefits** for the following services.

Lifetime Maximum
There is a lifetime maximum benefit per Member as shown in the **Schedule of Benefits**. This benefit only applies to Members under the age of 19.

When orthodontic treatment is in progress on the Effective Date of coverage, benefits will not be provided for services rendered prior to the Effective Date but will be provided for charges incurred after this date for continuing treatments on the dates performed.

Orthodontic treatment and services for the correction of malocclusion if due to:
1. an overbite or overjet of at least 4 millimeters;
2. upper and lower arches in a protrusive or retrusive relation of at least 1 cusp;
3. a cross-bite; or
4. an arch length discrepancy of more than 4 millimeters in either the upper or lower arch.

These services include, but are not limited to:
1. preventive treatment procedures;
2. removable or fixed appliance therapy; and
3. treatment of transitional and permanent dentition.

What's Not Covered by your Dental Plan

1. Charges incurred before a Member was covered by this dental benefit, except as stated under the "Covered Expenses" section.
2. Services rendered by a provider who is a close relative or member of your household. Close relative means wife or husband, parent, child, brother or sister by blood, marriage or adoption.
3. Charges for which You or a Covered Dependent have no obligation to pay. This does not include the cost of services and supplies provided by Medicaid or those services provided by the Veterans Administration for a non-service-related Illness or Injury.
4. Any part of the normal charge for services or supplies which a Dentist offers to waive. This includes, but is not limited to, Deductibles and Coinsurance.
5. Charges for treatment that is not considered to be Medically Necessary or Reasonable and Customary. BCBSGA determines, with the advice of medical or dental peer groups or other experts, what services, treatments or supplies are Medically Necessary and if charges are Reasonable and Customary.
6. Charges for treatment which BCBSGA considers to be Experimental or Investigational. We determine, with the advice of medical or dental peer groups or other experts, whether or not a procedure is Experimental or Investigational.
7. Charges which are not considered Covered Expenses due to Pre-Determination of Benefits.
8. Any Injury for which Workers' Compensation benefits, occupational injury benefits or personal liability benefits are payable. This exclusion does not apply if You are a partner or proprietor and You are not entitled to Workers' Compensation benefits.
9. Services not provided by a Dentist, except the scaling and cleaning of teeth performed by a dental hygienist under the Dentist's supervision.
10. Services or treatment which do not have a reasonably favorable prognosis.
11. Charges for nitrous oxide, novocaine, xylocaine or any similar local anesthetic when the charge is made separately from a covered dental expense.
12. Any treatment for cosmetic purposes, including, but not limited to facings on crowns or pontics posterior to the second bicuspid, unless the treatment is Medically Necessary to restore teeth lost or damaged due to an Accidental Injury which occurred while covered by this Plan.
13. Personalization of dentures or teeth.
14. Charges for plaque control programs and dietary instruction.
15. Replacement of prosthetic devices, dentures, bridges or crowns within 5 years of its last placement.
16. Replacement of lost or stolen prosthetic devices or appliances.
17. Charges to adjust a prosthetic device within the first 6 months of its placement and which were not included in the device's original price.
18. Occlusal equilibration, except treatment due to periodontal disease.
19. Crowns, inlays, onlays or gold fillings, unless the extent of the cavity or fracture prevents the use of an amalgam, silicate, acrylic, synthetic, porcelain or composite filling.
20. Treatment furnished or available to you in whole or in part under the laws of the United States, or any state, or political subdivision.
21. Treatment for any condition, disease, ailment, injury, or diagnostic service to the extent that benefits are provided, or would have been provided had a claim been filed, under title XVIII of the Social Security Act of 1965 (Medicare), including amendments thereto.

Coordination of Group Health and Dental Program Benefits

Any dental services eligible for coverage under your health care plan will be payable according to the provisions of the health care plan. No benefits are provided under the dental Plan for such services.

Dental Utilization Review

Dental utilization review is a process designed to promote the delivery of cost-effective dental care by encouraging the use of clinically recognized and proven procedures. Dental utilization review is included in Your dental benefits to encourage You to utilize Your dental benefits in a cost-effective and clinically recognized manner. Your right to benefits for Covered Services provided under this Plan is subject to certain policies, guidelines and limitations, including, but not limited to, the Claims Administrator's coverage guidelines, dental policy and utilization review features.

Dental utilization review is accomplished through pre-treatment review and retrospective review. The Claims Administrator's dental coverage guidelines for pre-treatment review and retrospective review are intended to reflect the standards of care for dental practice and state-specific regulations. The purpose of dental coverage guidelines is to assist in the interpretation of Medical Necessity. In order to be Covered Services under this Plan, services must meet the Medically Necessary requirements.

Pre-Treatment Review

You may have a pre-treatment review done before You receive benefits. Pre-treatment review is not a prior authorization for services but is a system that allows You and Your Dentist to know, in advance, what the estimated benefits payable would be under this Plan for a proposed course of treatment. The actual benefits You receive under the plan will be determined once a claim for services has been received and may vary from the estimated benefits based upon the actual services received as well as the benefit coverage in effect on the date(s) of services.

Under pre-treatment review, Your Dentist prepares a request for a pre-treatment benefit estimation form, and submits this form to the Claims Administrator before any treatment begins. The pre-treatment benefit estimation form should: (a) list the recommended dental services; and (b) show the charge for each dental service. The Claims Administrator will review this request and send a copy of its estimated benefits to You and Your Dentist. The Claims Administrator may request supporting pre-operative x-rays or other diagnostic records in connection with the pre-treatment review. A pre-treatment review is recommended if the proposed course of treatment is expected to involve charges of **$350 or more**.

If the course of treatment is not reviewed before treatment is received, it will be reviewed when the claim is submitted to the Claims Administrator for payment.

Retrospective Review

Retrospective review means a Medical Necessity review that is conducted after dental care services have been provided. A claim review includes, but is not limited to, an evaluation of reimbursement levels, accuracy of documentation, accuracy of coding and adjudication of payment.

The Claims Administrator provides a toll-free telephone number available during normal business hours to assist You or Your Dentist in obtaining information with respect to the Claims Administrator's utilization review process. This same number may be utilized after business hours to leave a message which will be responded to within two business days in non-emergency situations.

If a Member disagrees with a utilization review decision and wishes to file a Grievance, or appeal a decision previously made You will find details on how to do this in the Grievance and Appeals section of this Benefit Booklet. You may also contact the Claims Administrator's Member Services number on Your ID card.

The utilization review process is governed by laws and regulations, and may be modified from time to time by the Plan as those laws and regulations may require.

Dental Conditions of Service

The following conditions of service must be met for an expense incurred to be considered a Covered Service.

1. You must incur this expense while You are covered for dental benefits under this Plan. The expense is incurred on the date You receive the service or treatment for which the charge is made, except that for:

   a. Dentures and other similar Prosthetic devices: all expenses are incurred on the date the final impression is made.
   b. Fixed bridges, crowns, inlays, or onlays: all expenses are incurred on the date a tooth is first prepared.
   c. Root canal therapy: all expenses are incurred on the later of the dates that the pulp chamber is opened or a canal is explored to the apex.
   d. Periodontal surgery: all expenses are incurred on the date that the surgery is actually performed.

2. The service must be provided by a licensed Provider and must be for preventive dental care or for treatment of dental disease, defect or injury.

3. The expense must be incurred for a dental service or treatment that is included under the section Covered Services. Additional limits on Covered Services are included under specific benefits in the "Schedule of Benefits."

4. The expense must not be for a dental service or treatment listed in the Exclusions section. If the service or treatment is partially excluded, then only that portion which is not excluded will be considered a Covered Service.

5. The expense must not exceed any of the dental benefit maximums or limitations of this Plan.

How Maximum Allowable Amount is Determined

General

This section describes how the Plan determines the amount of reimbursement for Covered Services. Reimbursement for dental services rendered by Network and Non-Network Dentists is based on this Plan's Maximum Allowed Amount for the type of service performed.

The Maximum Allowed Amount for this Plan is the maximum amount of reimbursement the Plan will pay for services and supplies:

- that meet the Plan's definition of Covered Services, to the extent such services and supplies are covered under Your Plan and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in Your Benefit Booklet.

You will be required to pay a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copayment or Coinsurance. In addition, when You receive Covered Services from a Non-Network Dentist, You may be responsible for paying any difference between the Maximum Allowed Amount and the Dentist's actual charges. This amount can be significant.

When You receive Covered Services from a Dentist, the Plan will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the dental procedure. Applying these rules may affect the Claims Administrator's determination of the Maximum Allowed Amount. The Claims Administrator's application of these rules does not mean that the Covered Services You received were not Medically Necessary. It means the Claims Administrator has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, Your Dentist may have submitted the claim using several procedure codes when there is a single procedure code that includes all or a combination of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same dental Provider or other dental Providers, the Plan may reduce the Maximum Allowed Amounts for those additional, secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent a duplicate payment for a dental procedure that may have already been considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is a Network Dentist or a Non-Network Dentist.

Network Dentist

A Network Dentist or participating Dentist is a Dentist who is in the contracted network for this specific product or who has a participation contract with the Claims Administrator. For Covered Services performed by a Network Dentist or participating providers, the Maximum Allowed Amount for this Plan is the rate the Dentist has agreed with the Claims Administrator to accept as reimbursement for the Covered Services. Because Network Dentists and participating providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send You a bill or collect for amounts above the Maximum Allowed Amount. However, You may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible, or have

a copay or coinsurance. Please call Member Services for help in finding a Network Dentist or participating provider or visit www.bcbsga.com.

Non-Network Dentist

Dentists who have not signed any contract with the Claims Administrator and are not in any of the Claims Administrator's networks are Non-Network Dentists.

For Covered Services You receive from a Non-Network Dentist, the Maximum Allowed Amount for this Plan will be one of the following:

1. An amount based on the Claims Administrator's Non-Participating provider fee schedule/rate, which the Claims Administrator has established in its discretion, and which the Claims Administrator reserves the right to modify from time to time, after considering one or more of the following: record fee data, reimbursement amounts accepted by like/similar providers contracted with the Claims Administrator, reimbursement amounts accepted by like/similar providers for the same services or supplies, or other industry cost, reimbursement and utilization data; or

2. An amount based on information provided by a third party vendor which may reflect comparable Providers' fees and costs to deliver care; or

3. An amount negotiated by the Claims Administrator or a third party vendor which has been agreed to by the Network Provider; or

4. An amount equal to the total charges billed by the Provider, but only if such charges are less than the Maximum Allowed Amount calculated by using one of the methods described above.

Providers who are not contracted for this product but contracted for other products with the Claims Administrator are also considered Non-Network. For this Plan, the Maximum Allowed Amount for services from these Providers will be one of the four methods shown above unless the contract between the Claims Administrator and that Provider specifies a different amount.

Unlike Network Dentists or participating providers, Non-Network Dentists may send You a bill and collect for the amount of the Dentist's charge that exceeds the Plan's Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Dentist charges. This amount can be significant. Choosing a Network Dentist or participating Dentist will likely result in lower out of pocket costs to You. Please call Member Services for help in finding a Network Dentist or visit the Claims Administrator's website at www.bcbsga.com.

Member Services is also available to assist You in determining this Plan's Maximum Allowed Amount for a particular service from a Non-Network Dentist. In order for the Claims Administrator to assist You, You will need to obtain from Your Dentist the specific procedure code(s) for the services the Dentist will render. You will also need to know the Dentist's charges to calculate Your out of pocket responsibility. Although Member Services can assist You with this pre-service information, the final Maximum Allowed Amount for Your claim will be based on the actual claim submitted by the Dentist.

Member Cost Share

For certain Covered Services and depending on Your plan design, You may be required to pay a part of the Maximum Allowed Amount as Your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

Your cost share amount and out of pocket limits may vary depending on whether You received services from a Network or Non-Network Dentist. Specifically, You may be required to pay higher cost sharing amounts or may have limits on Your benefits when using Non-Network Dentists. Please see the Schedule of Benefits in this Benefit Booklet for Your cost share responsibilities and limitations, or call

Member Services to learn how this Plan's benefits or cost share amounts may vary by the type of Dentist You use.

The Plan will not provide any reimbursement for non-covered services. You may be responsible for the total amount billed by Your Dentist for non- covered services, regardless of whether such services are performed by a Network or Non-Network Dentist. Both services specifically excluded by the terms of Your Plan and those received after benefits have been exhausted are non-covered services. Benefits may be exhausted by exceeding, for example, Your annual or lifetime maximum, benefit maximums or day/visit limits.

Claims Payment

Payment of Benefits

You authorize the Plan to make payments directly to Providers for Covered Services. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims sent to, an Alternate Recipient (any child of a Subscriber who is recognized, under a Qualified Medical Child Support Order (QMSCO), as having a right to enrollment under the Employer's Plan), or that person's custodial parent or designated representative. Any payments made by the Plan will discharge the Plan's obligation to pay for Covered Services. You cannot assign Your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA.

Once a Provider performs a Covered Service, the Plan will not honor a request to withhold payment of the claims submitted.

Notice of Claim

The Plan is not liable, unless the Claims Administrator receives written notice that Covered Services have been given to You. The notice must be given to the Claims Administrator within 90 days of receiving the Covered Services, and must have the data the Claims Administrator needs to determine benefits. If the notice submitted does not include sufficient data the Claims Administrator needs to process the claim, then the necessary data must be submitted to the Claims Administrator within the time frames specified in this provision or no benefits will be payable except as otherwise required by law.

If the Claims Administrator has not received the information it needs to process a claim, the Claims Administrator will ask for the additional information necessary to complete the claim. Generally, You will receive a copy of that request for additional information, for Your information. In those cases, the Claims Administrator cannot complete the processing of the claim until the additional information requested has been received. The Claims Administrator generally will make its request for additional information within 30 days of the Claims Administrator's initial receipt of the claim and will complete the Claims Administrator's processing of the claim within 15 days after the Claims Administrator's receipt of all requested information. An expense is considered incurred on the date the service or supply was given. **If the Claims Administrator is unable to complete processing of a claim because You or Your Provider fail to provide the Claims Administrator with the additional information within 60 days of its request, the claim will be denied and You will be financially responsible for the claim.**

Failure to give the Claims Administrator notice within 90 days will not reduce any benefit if You show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, either send a written request for claim forms to the Claims Administrator, or contact Member Services and ask for claim forms to be sent to You. If You do not receive the claim forms, written notice of services rendered may be submitted to the Claims Administrator without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient.
- Patient's relationship with the Subscriber.
- Identification number.
- Date, type and place of service.
- Your signature and the Provider's signature.

Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. Any Member who fails to cooperate (including a Member who fails to enroll under Part B of the Medicare program where Medicare is the responsible payor) will be responsible for any charge for services.

Explanation of Benefits

After You receive dental care, You will often receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage You receive. The EOB is not a bill, but a statement from the Plan to help You understand the coverage You are receiving. The EOB shows:

- Total amounts charged for services/supplies received.
- The amount of the charges satisfied by Your coverage.
- The amount for which You are responsible (if any).
- General information about Your appeals rights and for ERISA plans, information regarding the right to bring action after the Appeals Process.

Grievance and Appeal Procedures

This section explains and offers instructions on what to do if a Member disagrees with a denial or modification of a dental claim, or is dissatisfied with the dental treatment or a service rendered and wishes to file a Grievance or Appeal of a decision previously made.

Grievances

If a Member has a Grievance about any aspect of the Claims Administrator's service, such as the processing of a dental claim, dental treatment or services rendered the Member should contact the Claims Administrator's Member Services department. The Claims Administrator will acknowledge receipt of the Grievance and provide a resolution within the state's specified Grievance resolution time frames. A Member may file a verbal Grievance through the Claims Administrator's toll-free number or submit a written Grievance to the address listed below. If after working with the Claims Administrator the Member is not satisfied with the resolution of their Grievance, the Member may file an Appeal as explained in the Appeals section below:

Blue Cross and Blue Shield of Georgia, Inc.
Grievance Department
P.O. Box 659471; San Antonio, TX 78265-9471
1-800-627-0004

Appeals

A Member may file an Appeal either verbally or in writing. The Claims Administrator will acknowledge receipt of Your Appeal of a Grievance and provide a resolution within the state's specified Appeal resolution time frames. An Appeal may be filed with or without having first submitted a formal Grievance. An Appeal may be filed for any dental claim that has been denied in whole or in part or to request a reconsideration for any adverse Grievance decision. In the Appeal, please state plainly the reason(s) why the treatment or service should not have been denied or why the adverse Grievance decision should be reversed. All clinical Appeals will be reviewed by an individual not previously involved in the original decision. Any documents or information not originally submitted should be included that may have a bearing on the Claims Administrator's decision.

Please send written Appeals to the following address or contact the Claims Administrator at the toll-free phone number listed below:

Blue Cross and Blue Shield of Georgia, Inc.
Appeals Department
P.O. Box 659471; San Antonio, TX 78265-9471
1-800-627-0004

The Member may designate a representative (e.g., Your dental care provider or anyone else of Your choosing) to file a Grievance or Appeal on Your behalf. The Claims Administrator must receive a written designation before working with Your representative.

The Grievance and Appeals process is governed by laws and regulations, and may be modified from time to time by the Claims Administrator, in agreement with the Employer, as those laws may require.

Both TTY/TDD services for the hearing and speech impaired and language translation assistance are available upon request to assist the Member in filing a Grievance or Appeal.

Expedited Appeal and/or Expedited Independent External Review

For pre-treatment denials based on utilization review, an expedited Appeal and/or expedited independent external review, may be available to the Member based on state specific requirements.

In the case of a benefit denial based on a retrospective review, an independent external review Appeal may also be available based on state specific requirements.

Grievances and Appeals by Members of ERISA Plans

If You are covered under an Employer plan which is subject to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), You must file a Grievance prior to bringing a civil action under 29 U.S.C. 1132 §502(a). An Appeal of a Grievance decision is a voluntary level of review and need not be exhausted prior to filing suit. Any statutes of limitations or other defenses based upon timeliness will be tolled while an Appeal is pending. You will be notified of Your right to file a voluntary Appeal if the Claims Administrator's response to Your Grievance is adverse. Upon Your request, the Claims Administrator will also provide You with detailed information concerning an Appeal, including how panelists are selected.

Coordination of Benefits (COB)

Coordination Of Benefits

This Coordination of Benefits (COB) provision applies when You have dental care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Benefit Booklet, e.g., Plan. For this provision only, "Plan" will have the meanings as specified below. In the rest of the Benefit Booklet, Plan has the meaning listed in the **Definitions** section.

The order of benefit determination rules determine the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

Because the Allowable expense may be the higher of the Primary and Secondary Plans' allowable amounts, a Network Provider may be allowed to bill You for any remaining Coinsurance, Deductible, and/or Copayment under the higher allowable amount. This higher allowable amount may be more than the Plan's allowed amount.

COB DEFINITIONS

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes: Group and non group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.

2. Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means the part of the contract providing dental care benefits that the COB provision applies to and which may be reduced because of the benefits of other plans. Any other part of the contract providing dental care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when You have dental care coverage under more than one Plan.
When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense is a health or dental care expense, including Deductibles and/or Coinsurance, that is covered at least in part by any Plan covering You. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering You is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging You is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

1. If You are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

2. If You are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

3. If You are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.

4. The amount of any benefit reduction by the Primary Plan because You have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and Network Provider arrangements.

Closed panel plan is a Plan that provides dental care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When You are covered by two or more Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

1. Except as provided in Paragraph 2. below, a Plan that does not contain a coordination of benefits

provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.

2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule 1 - Non-Dependent or Dependent. The Plan that covers You other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers You as a Dependent is the Secondary Plan. However, if You are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering You as a Dependent and primary to the Plan covering You as other than a Dependent (e.g., a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering You as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering You as a Dependent is the Primary Plan.

Rule 2 - Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:

    - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

    - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

2. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

    - If a court decree states that one of the parents is responsible for the Dependent child's dental care expenses or dental care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

    - If a court decree states that both parents are responsible for the Dependent child's dental care expenses or dental care coverage, the provisions of 1. above will determine the order of benefits;

    - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the dental care expenses or dental care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or

    - If there is no court decree assigning responsibility for the Dependent child's dental care expenses or dental care coverage, the order of benefits for the child are as follows:

        - The Plan covering the Custodial parent;

- The Plan covering the spouse of the Custodial parent;
- The Plan covering the non-custodial parent; and then
- The Plan covering the spouse of the non-custodial parent.

3. For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of items 1 or 2 above will determine the order of benefits as if those individuals were the parents of the child.
4. For a Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouses plan, Rule 5 applies. In the event the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the order of benefits will be determined by applying the birthday rule in item 1 above to the Dependent child's parent(s) and the Dependent's spouse.

Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers You as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering You as a retired or laid-off employee is the Secondary Plan. The same would hold true if You are a Dependent of an active employee and You are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 4 - COBRA. If You are covered under COBRA or under a right of continuation provided by other federal law and are covered under another Plan, the Plan covering You as an employee, member, subscriber or retiree or covering You as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits. This rule does not apply when the person is covered either: (a) as a non- dependent under both Plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as an employee or as a retired employee and is covered under his or her own Plan as an employee, member, subscriber or retiree); or (b) as a Dependent under both plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as a dependent of an employee, member or subscriber or retired employee and is covered under the other plan as a dependent of an employee, member, subscriber or retiree).

Rule 5 - Longer or Shorter Length of Coverage. The Plan that covered You longer is the Primary Plan and the Plan that covered You the shorter period of time is the Secondary Plan.

Rule 6. If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim.

Because the Allowable expense is generally the higher of the Primary and Secondary Plans' allowable amounts, a Network Provider can bill You for any remaining Coinsurance, Deductible and/or Copayment under the higher allowable amount. In addition, the Secondary Plan will credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If You are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB will not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about dental care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. The Claims Administrator may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. The Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Claims Administrator any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, This Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. This Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by This Plan is more than should have paid under this COB provision, the Claims Administrator, may recover the excess from one or more of the persons:

1. The Plan has paid or for whom the Plan have paid; or
2. Any other person or organization that may be responsible for the benefits or services provided for the Member.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Subrogation and Reimbursement

These provisions apply when the Plan pays benefits as a result of injuries or illnesses You sustained and You have a right to a Recovery or have received a Recovery from any source.

Recovery
A "Recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, workers' compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how You or Your representative or any agreements characterize the money You receive as a Recovery, it shall be subject to these provisions.

Subrogation
The Plan has the right to recover payments it makes on Your behalf from any party responsible for compensating You for Your illnesses or injuries. The following apply:

- The Plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether You are fully compensated, and regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.

- You and Your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights.

- In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

- The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan.

- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by You, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to Your claim, Your attorney fees, other expenses or costs.

- The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs You incur. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Reimbursement
If You obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on Your behalf, the Plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on Your behalf and the following provisions will apply:

- You must promptly reimburse the Plan from any Recovery to the extent of benefits the Plan paid on Your behalf regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.

- Notwithstanding any allocation or designation of Your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery. Further, the Plan's rights will not be reduced due to Your negligence.

- You and Your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (*i.e.*, the total amount of Your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon Your receipt of the Recovery. You and Your legal representative

acknowledge that the portion of the Recovery to which the Plan's equitable lien applies is a Plan asset.

- Any Recovery You obtain must not be dissipated or disbursed until such time as the Plan has been repaid in accordance with these provisions.

- You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

- If You fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of Your Recovery whichever is less, from any future benefit under the Plan if:

  1. The amount the Plan paid on Your behalf is not repaid or otherwise recovered by the Plan; or
  2. You fail to cooperate.

- In the event that You fail to disclose the amount of Your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.

- The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of Your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on Your behalf. In such a circumstance, it may then be Your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse You.

- The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate You or make You whole.

Your Duties

- You must promptly notify the Plan of how, when and where an accident or incident resulting in personal injury or illness to You occurred, all information regarding the parties involved and any other information requested by the Plan.

- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

- You must not do anything to prejudice the Plan's rights.

- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to You.

- You must promptly notify the Plan if You retain an attorney or if a lawsuit is filed on Your behalf.

- You must immediately notify the Plan if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

The Plan Sponsor has sole discretion to interpret the terms of the Subrogation and Reimbursement provision of this Plan in its entirety and reserves the right to make changes as it deems necessary.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision. Likewise, if the covered person's

relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, that Recovery shall be subject to this provision.

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal injury protection policy regardless of any election made by You to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

General Information

Entire Agreement

This Benefit Booklet, the Administrative Services Agreement, the Employer's application, any Riders, Endorsements or attachments, and the individual applications of the Subscribers and Members, if any, constitute the entire agreement between the Claims Administrator and the Employer and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Claims Administrator by the Employer, and any and all statements made to the Employer by the Claims Administrator, are representations and not warranties, and no such statement unless it is contained in a written application for coverage under the Plan, shall be used in defense to a claim under the Plan.

Form or Content of Benefit Booklet

No agent or employee of the Claims Administrator is authorized to change the form or content of this Benefit Booklet. Such changes can be made only through an endorsement authorized and signed by an officer of the Employer.

Circumstances Beyond the Control of the Plan

The Claims Administrator shall make a good-faith effort to arrange for an alternative method of administering benefits. In the event of circumstances not within the control of the Claims Administrator or Employer, including but not limited to: a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, labor disputes not within the control of the Claims Administrator, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of dental care services provided by the Plan is delayed or rendered impractical the Claims Administrator shall make a good-faith effort to arrange for an alternative method of administering benefits. In such event, the Claims Administrator and Network Providers shall administer and render services under the Plan insofar as practical, and according to their best judgment; but the Claims Administrator and Network Providers shall incur no liability or obligation for delay, or failure to administer or arrange for services if such failure or delay is caused by such an event.

Protected Health Information Under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Privacy Regulations issued under HIPAA, contain provisions designed to protect the privacy of certain individually identifiable health information. Your Employer's Group Health Plan has a responsibility under the HIPAA Privacy Regulations to provide You with a Notice of Privacy Practices. This notice sets forth the Employer's rules regarding the disclosure of Your information and details about a number of individual rights You have under the Privacy Regulations. As the Claims Administrator of Your Employer's Plan, Anthem has also adopted a number of privacy practices and has described those in its Privacy Notice. If You would like a copy of Anthem's Notice, contact the Member Services number on the back of Your Identification Card.

Workers' Compensation

The benefits under the Plan are not designed to duplicate any benefit for which Members are eligible under the Workers' Compensation Law. All sums paid or payable by Workers' Compensation for services provided to a Member shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Workers' Compensation or equivalent employer liability or indemnification law.

Other Government Programs

Except insofar as applicable law would require the Plan to be the primary payor, the benefits under the Plan shall not duplicate any benefits to which Members are entitled, or for which they are eligible under any other governmental program. To the extent the Plan has duplicated such benefits, all sums payable under such programs for services to Members shall be paid by or on behalf of the Member to the Plan.

Medicare Program

When You are eligible for the Medicare program and Medicare is allowed by federal law to be the primary payor, the benefits described in this Benefit Description will be reduced by the amount of benefits allowed under Medicare for the same *covered services*. This reduction will be made whether or not You actually receive the benefits from Medicare.

If You Are Under Age 65 With End Stage Renal Disease (ESRD)

If You are under age 65 and eligible for Medicare only because of ESRD (permanent kidney failure), the Plan will provide the benefits described in this Benefit Description before Medicare benefits. This includes the Medicare "three month waiting period" and the additional **30 months** after the Medicare effective date. After 33 months, the benefits described in this Benefit Description will be reduced by the amount that Medicare allows for the same *covered services*.

If You Are Under Age 65 With Other Disability

If You are under age 65 and eligible for Medicare only because of a disability other than ESRD, the Plan will provide the benefits described in this Benefit Description before Medicare benefits. This is the case **only** if You are the actively employed S*ubscriber* or the enrolled Spouse or child of the actively employed S*ubscriber*.

If You Are Age 65 or Older

If You are age 65 or older and eligible for Medicare only because of age, the Plan will provide the benefits described in this Benefit Description before Medicare. This can be the case **only** if You are an actively employed S*ubscriber* or the enrolled Spouse of the actively employed S*ubscriber*.

Right of Recovery and Adjustment

Whenever payment has been made in error, the Plan will have the right to recover such payment from You or, if applicable, the Provider or otherwise make appropriate adjustment to claims. In most instances such recovery or adjustment activity shall be limited to the calendar year in which the error is discovered

The Claims Administrator has oversight responsibility for compliance with Provider and vendor contracts. The Claims Administrator may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. Additionally, The Claims Administrator has established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses and settle or compromise recovery or adjustment amounts. The Claims Administrator will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount.

Relationship of Parties (Employer-Member-Claims Administrator)

Neither the Employer nor any Member is the agent or representative of the Claims Administrator.

The Employer is fiduciary agent of the Member. The Claims Administrator's notice to the Employer will constitute effective notice to the Member. It is the Employer's duty to notify the Claims Administrator of eligibility data in a timely manner. The Claims Administrator is not responsible for payment of Covered Services of Members if the Employer fails to provide the Claims Administrator with timely notification of Member enrollments or terminations.

Note

The Employer, on behalf of itself and its Members, hereby expressly acknowledges its understanding that the Administrative Services Agreement (which includes this Benefit Booklet) constitutes a contract solely between the Employer and BCBSGA and that BCBSGA is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the State of Georgia. The Blue Cross and Blue Shield

marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield Plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of the Administrative Services Agreement or this Benefit Booklet.

Notice

Any notice given under the Plan shall be in writing. The notices shall be sent to: The Employer at its principal place of business; to You at the Subscriber's address as it appears on the records or in care of the Employer.

Modifications or Changes in Coverage

The Plan Sponsor may change the benefits described in this Benefit Booklet and the Member will be informed of such changes as required by law. This Benefit Booklet shall be subject to amendment, modification, and termination in accordance with any of its provisions by the Employer, or by mutual agreement between the Claims Administrator and the Employer without the consent or concurrence of any Member. By electing [medical and hospital] benefits under the Plan or accepting the Plan benefits, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, and provisions hereof.

Fraud

Fraudulent statements on Plan enrollment forms or on electronic submissions will invalidate any payment or claims for services and be grounds for voiding the Member's coverage.

Acts Beyond Reasonable Control (Force Majeure)

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

The Claims Administrator will adhere to the Plan Sponsor's instructions and allow the Plan Sponsor to meet all of the Plan Sponsor's responsibilities under applicable state and federal law. It is the Plan Sponsor's responsibility to adhere to all applicable state and federal laws and the Claims Administrator does not assume any responsibility for compliance.

Conformity with Law

Any provision of the Plan which is in conflict with the applicable federal laws and regulations is hereby amended to conform with the minimum requirements of such laws.

Clerical Error

Clerical error, whether of the Claims Administrator or the Employer, in keeping any record pertaining to this coverage will not invalidate coverage otherwise validly in force or continue benefits otherwise validly terminated.

Policies and Procedures

The Claims Administrator may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Plan with which a Member shall comply.

Under the terms of the Administrative Service Agreement with Your Employer, the Claims Administrator has the authority, in its discretion, to institute from time to time, utilization management, case management, disease management or wellness pilot initiatives in certain designated geographic areas. These pilot initiatives are part of the Claims Administrator's ongoing effort to find innovative ways to make

available high quality and more affordable healthcare. A pilot initiative may affect some, but not all Members under the Plan. These programs will not result in the payment of benefits which are not provided in the Employer's Group Dental Plan, unless otherwise agreed to by the Employer. The Claim's Administrator reserves the right to discontinue a pilot initiative at any time without advance notice to Employer.

Waiver

No agent or other person, except an authorized officer of the Employer, has authority to waive any conditions or restrictions of the Plan, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Employer's Sole Discretion

The Employer may, in its sole discretion, cover services and supplies not specifically covered by the Plan. This applies if the Employer, with advice from the Claims Administrator, determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Reservation of Discretionary Authority

The Claims Administrator shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation of the Plan and interpretation of the Benefit Booklet. This includes, without limitation, the power to construe the Administrative Services Agreement, to determine all questions arising under the Plan, to resolve Member Appeals and to make, establish and amend the rules, regulations and procedures with regard to the interpretation of the Benefit Booklet of the Plan. A specific limitation or exclusion will override more general benefit language. Anthem has complete discretion to interpret the Benefit Booklet. The Claims Administrator's determination shall be final and conclusive and may include, without limitation, determination of whether the services, treatment, or supplies are Medically Necessary, Experimental/Investigative, whether surgery is cosmetic, and whether charges are consistent with the Plan's Maximum Allowable Amount. A Member may utilize all applicable Appeals procedures.

Care Received Outside the United States

You will receive Plan benefits for care and treatment received outside the United States. Plan provisions will apply. Any care received must be a Covered Service. Please pay the provider of service at the time You receive treatment and obtain appropriate documentation of services received including bills, receipts, letters and medical narrative. This information should be submitted with Your claim. All services will be subject to appropriateness of care. The Plan will reimburse You directly. Payment will be based on Eligible Charges and based on the Maximum Allowed Amount of the Member's legal residence (i. e., local Maximum Allowed Amount). Assignments of benefits to foreign providers or facilities cannot be honored.

You may be required to complete an authorization form in order to have Your claims and other personal information sent to the Claims Administrator when You receive care in foreign countries. Failure to submit such authorizations may prevent foreign providers from sending Your claims and other personal information to the Claims Administrator.

Governmental Health Care Programs

Under federal law, for groups with 20 or more Employees, all active Employees (regardless of age) can remain on the Group's Health Plan and receive group benefits as primary coverage. Also, Spouses (regardless of age) of active Employees can remain on the Group's Health Plan and receive group benefits as primary coverage. Direct any questions about Medicare eligibility and enrollment to Your local Social Security Administration office.

When Your Coverage Terminates

Termination of Coverage (Individual)

Membership for You and Your enrolled family members may be continued as long as You are employed by the Employer and meet eligibility requirements. It ceases if Your employment ends, if You no longer meet eligibility requirements, if the Plan ceases, or if You fail to make any required contribution toward the cost of Your coverage. In any case, Your coverage would end at the expiration of the period covered by Your last contribution.

Coverage of an enrolled child ceases automatically at the end of the month when the child attains the age limit shown in the Eligibility section. Coverage of a disabled child over age 26 ceases if the child is found to be no longer totally or permanently disabled.

Coverage of the Spouse of a Subscriber terminates automatically as of the date of divorce or death.

Continuation of Coverage (Federal Law-COBRA)

If Your coverage ends under the Plan, You may be entitled to elect continuation coverage in accordance with federal law. If Your employer normally employs 20 or more people, and Your employment is terminated for any reason other than gross misconduct You may elect from 18-36 months of continuation benefits. You should contact Your Employer if You have any questions about Your COBRA rights.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when Your group coverage would otherwise end because of certain “qualifying events.” After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, Your Spouse and Your Dependent children could become qualified beneficiaries if covered on the day before the qualifying event and group coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles each member of Your family who is enrolled in the company’s employee welfare benefit plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered Subscribers may elect COBRA continuation coverage on behalf of their Spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a covered Subscriber during the period of continuation coverage is also eligible for election of continuation coverage.

Qualifying Event	Length of Availability of Coverage
For Employees: Voluntary or Involuntary Termination (other than gross misconduct) or Loss of Coverage Under an Employer's Health Plan Due to Reduction In Hours Worked	18 months
For Spouses/ Dependents: A Covered Employee's Voluntary or Involuntary Termination (other than gross misconduct) or Loss of Coverage Under an Employer's Health Plan Due to Reduction In Hours Worked Covered Employee's Entitlement to Medicare Divorce or Legal Separation Death of a Covered Employee	18 months 36 months 36 months 36 months
For Dependents: Loss of Dependent Child Status	36 months

Continuation coverage stops before the end of the maximum continuation period if the Member becomes entitled to Medicare benefits. If a continuing beneficiary becomes entitled to Medicare benefits, then a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. (For example, if You become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for Your Spouse and children can last up to 36 months after the date of Medicare entitlement.)

If You are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code may be a qualifying event. If a proceeding in bankruptcy is filed with respect to Your employer, and that bankruptcy results in the loss of coverage, You will become a qualified beneficiary with respect to the bankruptcy. Your surviving Spouse and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life. His or her Spouse and Dependents may continue coverage for a maximum period of up to 36 months following the date of the retiree's death.

Second qualifying event

If Your family has another qualifying event (such as a legal separation, divorce, etc.) during the initial 18 months of COBRA continuation coverage, Your Spouse and dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused Your Spouse or dependent children to lose coverage under the Plan had the first qualifying event not occurred. A qualified beneficiary must give timely notice to the Plan Administrator in such a situation.

Notification Requirements

In the event of Your termination, lay-off, reduction in work hours or Medicare entitlement, Your Employer must notify the company's benefit Plan Administrator within 30 days. You must notify the company's benefit Plan Administrator within 60 days of Your divorce, legal separation or the failure of Your enrolled

Dependents to meet the program's definition of Dependent. This notice must be provided in writing to the Plan Administrator. Thereafter, the Plan Administrator will notify qualified beneficiaries of their rights within 14 days.

To continue enrollment, You or an eligible family member must make an election within 60 days of the date Your coverage would otherwise end, or the date the company's benefit Plan Administrator notifies You or Your family member of this right, whichever is later. You must pay the total Premium appropriate for the type of benefit coverage You choose to continue. If the Premium rate changes for active associates, Your monthly Premium will also change. The Premium You must pay cannot be more than 102% of the Premium charged for Employees with similar coverage, and it must be paid to the company's benefit Plan Administrator within 30 days of the date due, except that the initial Premium payment must be made before 45 days after the initial election for continuation coverage, or Your continuation rights will be forfeited.

For Employees who are determined, at the time of the qualifying event, to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and Employees who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Employees' Dependents are also eligible for the 18 to 29-month disability extension. (This provision also applies if any covered family member is found to be disabled.) This provision would only apply if the qualified beneficiary provides notice of disability status within 60 days of the disabling determination. In these cases, the Employer can charge 150% of Premium for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the disabled at 29 months. (If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, such qualified beneficiary must notify the Plan Administrator of that fact in writing within 30 days after the Social Security Administration's determination.)

Trade Adjustment Act Eligible Individual

If You don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused You to be eligible initially for COBRA coverage under this Plan, You will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which You become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period.

When COBRA Coverage Ends

These benefits are available without proof of insurability and coverage will end on the earliest of the following:

- a covered individual reaches the end of the maximum coverage period;
- a covered individual fails to pay a required Premium on time;
- a covered individual becomes covered under any other group health plan after electing COBRA;
- a covered individual becomes entitled to Medicare after electing COBRA; or
- the Group terminates all of its group welfare benefit plans.

Continuation of Coverage During Military Leave (USERRA)

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Member may have a right to continuation of benefits subject to the conditions described below.

Under USERRA, if the Employee (or his or her Dependents) is covered under this Plan, and if the Employee becomes absent from employment by reason of military leave, the Employee (or his or her Dependents) may have the right to elect to continue health coverage under the plan. In order to be eligible for coverage during the period that the Employee is gone on military leave, the Employee must give reasonable notice to the Employer of his or her military leave and the Employee will be entitled to COBRA-like rights with respect to his or her medical benefits in that the Employee and his or her Dependents can elect to continue coverage under the plan for a period of 24 months from the date the military leave commences or, if sooner, the period ending on the day after the deadline for the Employee

to apply for or return to work with the Employer. During military leave the Employee is required to pay the Employer for the entire cost of such coverage, including any elected Dependents' coverage. However, if the Employee's absence is less than 31 days, the employer must continue to pay its portion of the Premiums and the Employee is only required to pay his or her share of the Premiums without the COBRA-type 2% administrative surcharge.

Also, when the Employee returns to work, if the Employee meets the requirements specified below, USERRA states that the Employer must waive any exclusions and waiting periods, even if the Employee did not elect COBRA continuation. These requirements are (i) the Employee gave reasonable notice to his or her Employer of military leave, (ii) the military leave cannot exceed a prescribed period (which is generally five (5) years, except in unusual or extraordinary circumstances) and the Employee must have received no less than an honorable discharge (or, in the case of an officer, not been sentenced to a correctional institution), and (iii) the Employee must apply for reemployment or return to work in a timely manner upon expiration of the military leave (ranging from a single day up to 90 days, depending upon the period that he or she was gone). The Employee may also have to provide documentation to the Employer upon reemployment that would confirm eligibility. This protection applies to the Employee upon reemployment, as well as to any Dependent who has become covered under the Plan by reason of the Employee's reinstatement of coverage.

Continuation of Coverage Due to Family and Medical Leave (FMLA)

An employee may continue membership in the Plan as provided by the Family and Medical Leave Act. An employee who has been employed at least one year, within the previous 12 months is eligible to choose to continue coverage for up to 12 weeks of unpaid leave for the following reasons:

- The birth of the employee's child.
- The placement of a child with the employee for the purpose of adoption or foster care.
- To care for a seriously ill spouse, child or parent.
- A serious health condition rendering the employee unable to perform his or her job.

If the employee chooses to continue coverage during the leave, the employee will be given the same health care benefits that would have been provided if the employee were working, with the same premium contribution ratio. If the employee's premium for continued membership in the Plan is more than 30 days late, the *Employer* will send written notice to the employee. It will tell the employee that his or her membership will be terminated and what the date of the termination will be if payment is not received by that date. This notice will be mailed at least 15 days before the termination date.

If membership in the Plan is discontinued for non-payment of premium, the employee's coverage will be restored to the same level of benefits as those the employee would have had if the leave had not been taken and the premium payment(s) had not been missed. This includes coverage for eligible dependents. The employee will not be required to meet any qualification requirements imposed by the Plan when he or she returns to work. This includes: new or additional waiting periods; waiting for an open enrollment period; or passing a medical exam to reinstate coverage.
Please contact Your Human Resources Department for state specific Family and Medical Leave Act information.

For More Information
This notice does not fully describe the continuation coverage or other rights under the Plan. More information about continuation coverage and Your rights under this Plan is available from the Plan Administrator.

If You have any questions concerning the information in this notice or Your rights to coverage, You should contact Your Employer.

For more information about Your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S Department of Labor's Employee Benefits Security Administration (EBSA) in Your area, or visit the EBSA website at *www.dol.gov/ebsa*.

Definitions

Acceptable Services (also called Covered Services)
Acceptable Services are services and supplies provided in connection with those services which are determined to be:
1. Acceptable and necessary for the symptoms, diagnosis, or treatment of your dental condition.
2. Provided for the prevention, diagnosis, or direct care and treatment of the dental condition.
3. Within community standards of good dental practice.

Accidental Injury
Physical harm or disability that is the result of a specific unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental Injury does not include illness or infection, except infection of a cut or wound**.** Damage to teeth due to chewing or biting is not an Accidental Injury.

Administrative Services Agreement
The agreement between the Claims Administrator and the Employer regarding the administration of certain elements of the health care benefits of the Employer's Group Dental Plan. This Benefit Booklet in conjunction with the Administrative Services Agreement, the application, if any, any amendment or rider, Your Identification Card and Your application for enrollment constitutes the entire Plan. If there is any conflict between either this Benefit Booklet or the Administrative Services Agreement and any amendment or rider, the amendment or rider shall control. If there is any conflict between this Benefit Booklet and the Administrative Services Agreement, the Administrative Services Agreement shall control.

Appeal
A formal request by You or Your representative for reconsideration of an adverse decision on a Grievance or claim.

Appliance
A dental device used to perform a therapeutic or corrective function.

Benefit Period
One year, January 1 – December 31 (also called year or the calendar year). It does not begin before a Member's Effective Date. It does not continue after a Member's coverage ends.**]**

Benefit Waiting Period
The period of continuous coverage under the Plan that a Member must complete following his or her Effective Date before dental benefits are payable for Covered Services. No payment will be made for expenses incurred during the Benefit Waiting Period indicated in the Schedule of Benefits.

Claims Administrator

The company the Plan Sponsor chose to administer its dental benefits. Blue Cross and Blue Shield of Georgia, Inc. was chosen to administer this Plan. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Coinsurance
A percentage of the Maximum Allowed Amount for which You are responsible to pay. Your Coinsurance will not be reduced by refunds, rebates, or any other form of negotiated post-payment adjustments.

Coordination of Benefits
A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment.

It avoids claims payment delays by establishing an order in which plans pay their claims and providing an authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first.

Covered Dependent

Any Dependent in a Subscriber's family who meets all the requirements of the Eligibility section of this Benefit Booklet, has enrolled in the Plan, and is subject to Administrative Service Fee requirements set forth by the Plan.

Covered Services

Services or treatment as described in the Benefit Booklet which are performed, prescribed, directed or authorized by a Dentist. To be considered Covered Services, services must be:

- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Plan is in force;
- Within the Maximum Allowed Amount;
- Medically Necessary;
- Not specifically excluded or limited by the Benefit Booklet; and
- Specifically included as a benefit within the Benefit Booklet.

Dental Condition

A covered Dental Condition that is not due to Accidental Injury. Dental "illness" means a disease or condition that results in damage or deterioration of sound and natural teeth, gums, or other oral tissue.

Dental Deductible

The dollar amount of Covered Services listed in the Schedule of Benefits for which You are responsible before the Plan starts to pay for Covered Services each Benefit Period.

Dentist

A person who is licensed to practice dentistry by the governmental authority having jurisdiction over the licensing and practice of dentistry.

Dental Plan Document

This Benefit Booklet in conjunction with the Dental Plan Document, the application, if any, any amendment or rider, Your Identification Card and Your application for enrollment constitutes the entire Plan. If there is any conflict between either this Benefit booklet or the Dental Plan Document and any amendment or rider, the amendment or rider shall control. If there is any conflict between this Benefit Booklet and the Dental Plan Document, the Dental Plan Document shall control.

Dependent

The Spouse and all children until attaining age limit stated in the Eligibility section. Children include natural children, legally adopted children, and stepchildren. Also included are Your children (or children of Your Spouse) for whom You have legal responsibility resulting from a valid court decree. Mentally retarded or physically disabled children remain covered no matter what age. You must give the Claims Administrator evidence of Your child's incapacity within 31 days of attainment of age 26. The certification form may be obtained from the Claims Administrator or Your Employer. This proof of incapacity may be required annually by the Plan. Such children are not eligible under this Plan if they are already 26 or older at the time coverage is effective.

Effective Date
The date for which the Plan approves an individual application for coverage. For individuals who join this Plan after the first enrollment period, the Effective Date is the date the Plan approves each future Member according to its normal procedures.

Employee
A person who is engaged in active employment with the Employer and is eligible for Plan coverage under the employment regulations of the Employer. The Employee is also called the Subscriber.

Employer
An Employer who has allowed its Employees to participate in the Plan by acting as the Plan Sponsor or adopting the Plan as a participating Employer by executing a formal document that so provides.

Experimental Procedures
Procedures not yet recognized by the American Dental Association as indicated with a specific procedure code designation, or procedures which are not widely accepted as proven and effective procedures within the organized dental community.

Grievance
Any expression of dissatisfaction made by You or Your representative to the Plan or its affiliates in which You have the reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. A Grievance is considered filed with the Plan on the day and time it is received. Grievances may include, but are not limited to, concerns about:

- the availability of Providers;
- the handling or payment of claims for dental care services;
- matters pertaining to the contractual relationship between You and the Plan or the Employer and the Administrator.

Group Dental Plan or Plan
An employee welfare benefit plan (as defined in Section 3(1) of ERISA, established by the Employer, in effect as of the Effective Date.

Identification Card
The latest card given to You showing Your identification and group numbers, the type of coverage You have and the date coverage became effective.

Initial Enrollee
A person actively employed by the Employer (or one of that person's Covered Dependents) who was either previously enrolled under the group coverage which this Plan replaces or who is eligible to enroll on the Effective Date of this Plan.

Injury
Bodily harm from a non-occupational accident.

Late Enrollees
Late Enrollees mean Employees or Dependents who request enrollment in a dental benefit plan after the initial open enrollment period. An individual will not be considered a Late Enrollee if: (a) the person enrolls during his/her initial enrollment period under the Plan: (b) the person enrolls during a special enrollment period; or (c) a court orders that coverage be provided for a minor Covered Dependent under a Member's Plan, but only as long as the Member requests enrollment for such Dependent within thirty-

one (31) days after the court order is so issued. Late Enrollees are those who declined coverage during the initial open enrollment period and did not submit a certification to the Plan that coverage was declined because other coverage existed.

Maximum Allowed Amount
The maximum amount of reimbursement for Covered Services under the Pan, as outlined under the section “How Maximum Allowed Amount Is Determined” section of this Benefit Booklet

Medically Necessary (Medical Necessity)
Medically Necessary procedures, services or treatments are those which are:

1. Appropriate and necessary for the symptoms, diagnosis, or treatment of the Dental Condition;
2. Customarily provided for the prevention, diagnosis, or direct care and treatment of the Dental Condition;
3. Within standards of good dental practice within the organized dental community;
4. Not primarily for Your convenience, or the convenience of Your Dentist or another Dentist; and
5. Based on prevailing dental practices, the least expensive Covered Service suitable for Your Dental Condition which will produce a professionally satisfactory result.

Member
Individuals, including the Subscriber and his/her Dependents, who have satisfied the Plan eligibility requirements of the Employer, applied for coverage, and been enrolled for Plan benefits.

Negotiated Rate
The Negotiated Rate is the rate of payment for Services that the Claims Administrator has negotiated with Participating Providers under a Participating Agreement for Covered Services furnished to covered Members.

New Hire
A person who is not employed by the Employer on the original Effective Date of the Plan.

Non-Participating Provider
A Dentist or Physician that does not have a participating agreement with the Claims Administrator to provide services at the time services are rendered.

Participating Provider
A Dentist or Physician who has in effect a Participating Agreement with the Claims Administrator at the time services are rendered. Participating Dentists or Providers have negotiated certain charges as the Negotiated Fee Rate they will charge Members for Covered Services.

Plan Administrator
The person or entity named by the Plan Sponsor to manage the Plan and answer questions about Plan details. ***The Plan Administrator is not the Claims Administrator.***

Plan Sponsor
The legal entity that has adopted the Plan and has authority regarding its operation, amendment and termination.

Prosthesis (Prosthetics)
A restorative service used to replace one or more missing or broken teeth and associated tooth structures. It includes all types of crowns, pontics, inlays, onlays, bridges, and dentures that are Covered Services.

Provider
A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves. This includes any Provider rendering services that are required by applicable state law to be covered when rendered by such Provider.

QMCSO, or MCSO – Qualified Medical Child Support Order or Medical Child Support Order
A QMCSO creates or recognizes the right of a child who is recognized under the order as having a right to be enrolled under the dental benefit plan to receive benefits for which the Employee is entitled under the plan; and includes the name and last known address of the Employee and each such child, a reasonable description of the type of coverage to be provided by the plan, the period for which coverage must be provided and each plan to which the order applies.
An MCSO is any court judgment, decree or order (including a court's approval of a domestic relations settlement agreement) that:

- provides for child support payment related to dental benefits with respect to the child of a group dental plan Member or requires dental benefit coverage of such child in such plan, and is ordered under state domestic relations law; or
- enforces a state law relating to medical child support payment with respect to a group dental plan.

Treatment Plan
A detailed description, submitted by the Dentist, outlining the proposed services and fees including any appropriate radiographs and diagnostic information.

You and Your
Refer to the Subscriber, Member and each Covered Dependent.

Health Benefits Coverage Under Federal Law

Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")

If You or Your spouse are required, due to a QMCSO, to provide coverage for Your child(ren), You may ask Your employer or Plan Administrator to provide You, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

Special Enrollment Notice

If You are declining enrollment for yourself or Your Dependents (including Your spouse) because of other health insurance coverage, You may in the future be able to enroll yourself or Your Dependents in this Plan, provided that You request enrollment within 31 days after Your other coverage ends.

In addition, if You have a new dependent as a result of marriage, birth, adoption, or placement for adoption, You may be able to enroll yourself and Your dependents. However, You must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligible Employees and Dependents may also enroll under two additional circumstances:

- the Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- the Employee or Dependent becomes eligible for a subsidy (state premium assistance program)

The Employee or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, call the Member Services telephone number on Your ID Card, or contact Your Plan Administrator.

Administered by Blue Cross and Blue Shield of Georgia, Inc., an Independent Licensee of the Blue Cross and Blue Shield Association