DENTAL BENEFIT PROGRAM WITH ORTHODONTICS

PLAN 135

BlueCross BlueShield of Georgia

F-1681.722 09/2010

CERTIFICATE OF COVERAGE

Blue Cross and Blue Shield of Georgia, Inc.
(herein called BCBSGA)
An Independent Licensee of the
Blue Cross and Blue Shield Association
Having issued a

Dental Master Contract

To
PLAN 135
(herein called the Group or Employer)

hereby certifies that

1. The persons and their eligible family members (if any) whose names are on file at the office of the Plan Administrator as being eligible for coverage, have had the required application for coverage accepted and subscription charge received by BCBSGA. These persons are covered under and subject to all the exceptions, limitations, and provisions of said Dental Master Contract for the benefits described herein;
2. Benefits will be paid in accordance with the provisions and limitations of the Dental Master Contract; and
3. BCBSGA has delivered to the Plan Administrator the Dental Master Contract covering certain persons and their eligible family members (if any) as Members of this Group program.

The Dental Master Contract (which includes this Certificate Booklet, and any amendments or riders) constitutes the entire Contract. All rights which may exist, arise from and are governed by this Dental Master Contract, and this Certificate Booklet does not constitute a waiver of any of the terms. The Dental Master Contract may be inspected at the office of the Plan Administrator.

Coverage under this Certificate will be effective and will continue in effect in accordance with the terms, provisions and conditions of the Dental Master Contract. This Certificate of Coverage replaces and supersedes all contracts and/or certificates which may have been issued previously by BCBSGA through the Plan Administrator.

The Contract was issued in the state of Georgia. Its laws and rules will govern in resolving any questions about the Contract.

C. Morgan Kendrick,
President

Table of Contents

Summary of Benefits	
All payments are based on Covered Expense.	
Yearly Maximum Maximum per calendar year per Member based on Covered Expense	$1,500
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%

Types of Coverage

Your type of coverage is determined by your selection at the time of enrollment through the Group.

Note: These benefits are valid for your current benefit period. You will receive a revised Summary of Benefits if there is a change in your Group benefits.

Summary Notice

This Certificate Booklet summarizes your employer's dental benefit program. The Certificate Booklet is written in an easy-to-read language to help you and your Dependents understand your dental benefits. It is issued as part of your employer's Dental Master Contract and governs your Group's coverage.

A thorough understanding of your coverage will enable you to use your benefits wisely. Please read this Certificate Booklet carefully. If you have any questions about your benefits as presented in this Certificate Booklet, please contact your employer's employee benefit specialist or call the BCBSGA Customer Service Department.

This Certificate Booklet is an integral part of your employer's Dental Master Contract. Its purpose is to help you understand your coverage and to provide an explanation of the benefits that your employer offers. Certain administrative details and legal rights provisions are included in a separate document which is held by your employer.

Customer Service

If you have a customer service question, please refer to the phone number on your Member I.D. card.

Notice

The laws of the State of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

Eligibility

Coverage for You
This booklet describes the benefits you may receive under your dental care program. You are called the Subscriber or Member.

Coverage for Your Dependents
If you're covered by this program, you may enroll your eligible Dependents. Your Covered Dependents are also called Members.

If the wrong birth date of a child is entered on an application, the child has no coverage for the period for which he or she is not legally eligible. Any overpayments made for coverage for any child under these conditions will be refunded by either you or BCBSGA.

Your eligible Dependents include:
- Your wife, husband or Domestic Partner;
- Your Dependent children through the end of the month in which they attain age 26, legally adopted children from the date you assume legal responsibility, children for whom you assume legal guardianship and stepchildren. Also included are your children (or children of your spouse or Domestic Partner) for whom you have legal responsibility resulting from a valid court decree.
- Children who are mentally or physically handicapped and totally dependent on you for support, regardless of age, with the exception of incapacitated children age 26 or older. To be eligible for coverage as an incapacitated Dependent, the Dependent must have been covered under this Contract or prior Creditable Coverage prior to reaching age 26. Certification of the handicap is required within 31 days of attainment of age 26. A certification form is available from your employer or from BCBSGA and may be required periodically but not more frequently than annually after the two year period following the child's attainment of the limiting age.

How to Enroll
Applications for membership may be obtained from your employer.

All groups which enroll for dental coverage that did not have prior dental coverage, have a 12-month waiting period for their Members for Type 3 Services. Check with your employer to determine waiting periods that may apply to you.

When Your Coverage Begins
If you apply when first eligible, your coverage will be effective on the date your Group's length-of-service requirement has been met. The Effective Date of coverage is subject to any length-of-service provision your Group requires.

If you do not enroll when first eligible, you will have a 12-month waiting period for Type 3 and Type 4 Services.

Types of Coverage
The types of coverage available to you are indicated at the time of enrollment through the Group.

Changing Your Coverage (Adding a Dependent)

You may add new Dependents to your Contract by contacting the Plan Administrator. You or the Plan Administrator must notify BCBSGA in writing. The Plan Administrator is the person named by your employer to manage the program and answer questions about program details.

Coverage is provided only for those Dependents you have reported to BCBSGA and added to your coverage by completing the correct Application.

Marriage and Stepchildren

A Member 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. Remember, there will be an additional charge.

If a Member does not apply for coverage to add a spouse and stepchildren within 31 days of the date of marriage, the spouse and stepchildren will be subject to a 12-month waiting period for Type 3 and Type 4 Services.

Newborn and Adopted Children

A newborn or an adopted child is covered automatically for 31 days from the moment of birth or date of assumption of legal responsibility up to age 26. If additional Premium is required to continue coverage beyond the 31-day period, the Member must notify BCBSGA of the birth or adoption and pay the required Premium within the 31-day period or coverage will terminate. Types of coverage requiring additional Premium include One-Person Coverage and Two-Person Coverage.

If a Member has family coverage or multi-person coverage, no additional Premium is required and coverage automatically continues. However, the Member should notify BCBSGA of the birth or adoption within 31 days to ensure accurate records and timely payment of claims.

If a Member does not apply for coverage to add a newborn or adopted child within 31 days of the date of birth or date of assumption of legal responsibility, the newborn or adopted child will have a 12-month waiting period for Type 3 and Type 4 Services.

Foster Children

Foster children are children of those whose parental rights have been terminated by the state and who have been placed in an alternative living situation by the state. A child does not become a foster child when the parents voluntarily relinquish parental power to a third party.

Foster children for whom a Member assumes legal responsibility are not covered automatically. In order for a foster child to have coverage, a Member must provide confirmation of a valid foster parent relationship to us. Such confirmation must be furnished at the Member's expense. When the application is processed, the Effective Date will be the first of the month following your Group's Employee waiting period.

Foster children have a 12-month waiting period for Type 3 and Type 4 Services.

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.

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 a 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

For groups with 50 or more employees, 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 Your Coverage or Removing a Dependent

When any of the following events occur, notify your 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 Your Coverage Terminates");
- Enrolled Dependent child becomes totally or permanently disabled.

Employee Not Actively at Work

New Hires

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 Group but not currently active due to health status.

Dental Benefits

Your Group's dental Contract 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 **Summary 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 Contract. We will pay the percentages listed in the Summary 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**, We will pay the percentages listed in the **Summary 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 this contract 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 **Summary 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 **Summary 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 **Summary 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 **Summary 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 **Summary 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

Your program pays the percentage of Covered Expense shown in the **Summary 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, your program pays the percentage of Covered Expense shown in the **Summary 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, your program pays the percentage of Covered Expense shown in the **Summary 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 Contract, and
- the replacement or addition of teeth is required to replace one or more additional natural teeth extracted while covered under this Contract 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

Your program pays the percentage of Covered Expense shown in the **Summary of Benefits** for the following services.

Lifetime Maximum
There is a lifetime maximum benefit per Member as shown in the **Summary 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 treatment of transitional and permanent dentition.

Pre-Determination of Benefits

When the anticipated expense for any course of treatment exceeds **$350**, the Member should submit to BCBSGA a request for a pretreatment benefit estimation as prepared by the attending Dentist on the appropriate form before the treatment commences.

You do not need a pre-determination of benefits for emergency or palliative care, and routine scaling or cleaning of teeth. If further treatment is recommended, You must send the necessary forms before the course of dental treatment is continued.

If necessary, We may request additional information such as x-rays, charts, models or written reports to help in the predetermination of benefits. This information must be provided at Your expense.

We may also reasonably request that the Member be examined, at its expense, by a Dentist of its choice.

Finally, We may recommend alternate treatment instead of the proposed dental service if, in our opinion, a professionally satisfactory result can be achieved at less cost. BCBSGA does not pay for covered expenses which exceed its estimates.

If a Member completes a course of dental treatment without predetermination, We will estimate benefits as if a pre-determination was requested. In this case, no benefits are payable for dental treatment which cannot be reasonably verified as being Medically Necessary or which is not allowed as alternate treatment.

What's Not Covered by your Dental Contract

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 Contract.
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 contract will be payable according to the provisions of the health care contract. No benefits are provided under the dental Contract for such services.

Coordination of Benefits (COB)

If you, your spouse, or your Dependents have duplicate coverage under another BCBSGA Group program, any other Group dental expense coverage, or any local, state or governmental program (except school accident insurance coverage and Medicaid), then benefits payable under this Contract will be coordinated with the benefits payable under the other program. The total benefits paid by both programs will not exceed 100% of Covered Expense, the per diem negotiated fee or the Contracted amount.

Allowable Expense means any Covered Expense at least a portion of which is covered under at least one of the programs covering the person for whom the claim is made. The claim determination period is the calendar year.

Order of Benefit Determination

When you have duplicate coverage, claims will be paid as follows:

- Automobile Insurance
  Dental benefits available through automobile insurance coverage will be determined before that of any other program if the automobile coverage has either no order of benefit determination rules or it has rules which differ from those permitted under applicable Georgia Insurance Regulations.
- Non-Dependent/Dependent
  The benefits of the program which covers the person as an Employee (other than as a Dependent) are determined before those of the program which covers the person as a Dependent.
- Dependent Child/Parents Not Separated or Divorced
  Except as stated below, when this program and another program cover the same child as a Dependent of different persons, called "parents":
  - The benefits of the program of the parent whose birthday falls earlier in a year are determined before those of the program of the parent whose birthday falls later in that year.
  - If both parents have the same birthday, the benefits of the program which covered the parent longer are determined before those of the program which covered the other parent for a shorter period of time.

  However, if the other program does not have the rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the programs do not agree on the order of benefits, the rule in the other program will determine the order of benefits.

- Dependent Child/Parents Separated or Divorced
  If two or more programs cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
  - first, the program of the parent with custody of the child;
  - then, the program of the spouse of the parent with custody of the child; and
  - finally, the program of the parent not having custody of the child.

  However, if the specific terms of a court decree state that one of the parents is responsible for the child's dental care expenses, and the company obligated to pay or provide the benefits of the program of that parent has actual knowledge of those terms, the benefits of that program are determined first. This paragraph does not apply with respect to any claim determination period or program year during which any benefits are actually paid or provided before the company has that actual knowledge.

- Joint Custody
  If the specific terms of a court decree state that the parents shall have joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the programs covering the child shall follow the order of benefit determination rules outlined above for "Dependent Child/Parents not Separated or Divorced."
- Active/Inactive Employee
  The benefits of a program that covers a person as an Employee who is neither laid off nor retired (or as that Employee's Dependent) are determined before those of a program that covers that person as a laid-off or retired Employee (or as that Employee's Dependent). If the other program does not have this rule, and if, as a result, the programs do not agree on the order of benefits, this rule is ignored.
- Longer/Shorter Length of Coverage
  If none of the above rules determine the order of benefits, the benefits of the program which covered an Employee or Member longer are determined before those of the program that covered that person for the shorter time.

Effect on the Benefits of this Program

This section applies when, in accordance with the Order of Benefit Determination Rules, this program is a secondary program to one or more other programs. In that event the benefits of this program may be reduced under this section. Such other program or programs are referred to as "the other programs" below.

Reduction in this program's benefits

The benefits of this program will be reduced when the sum of:

- the benefits that would be payable for the Allowable Expenses under this program in the absence of this provision; and
- the benefits that would be payable for the Allowable Expenses under the other programs, in the absence of provisions with a purpose like that of this provision, whether or not claim is made, exceed those Allowable Expenses in a claim determination period. In that case, the benefits of this program will be reduced so that they and the benefits payable under the other programs do not total more than those Allowable Expenses.

When the benefits of this program are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this program.

Miscellaneous Rights

- Right to Receive and Release Necessary Information
  Certain facts are needed to apply these rules. We have the right to decide which facts we need. We may get needed facts from or give them to any other organization or person as necessary to coordinate benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under this program must give us any facts needed to pay the claim.
- Facility of Payment
  A payment made under another program may include an amount which should have been paid under this program. If it does, we may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this program. We will not have to pay that amount again.
- Right of Reimbursement
  If the amount of the payment made by us is more than it should have paid under this provision, we may recover the excess from one or more of:
  - the persons we have paid or for whom we have paid,
  - insurance companies, or
  - other organizations.

Right of Recovery

If you or your Covered Dependents have a claim for damages or a right to reimbursement from a third party or parties for any condition, illness or Injury for which benefits are paid under this program, we shall have a right of recovery. Our right of recovery shall be limited to the amount of any benefits paid for covered dental expenses under this program, but shall not include non-dental items. Money received for future dental care or pain and suffering may not be recovered. Our right of recovery shall include compromise settlements. You or your attorney must inform us of any legal action or settlement discussion, ten days prior to settlement or trial. We will then notify you of the amount we seek, and the amount of your legal expenses we will pay.

Claims and General Information

Under normal conditions, BCBSGA should receive the proper claim form within 90 days after the service was provided. This section of your booklet describes when to file a benefits claim.

How to File Claims

Each person enrolled through the Group's dental program receives an Identification Card. Your Dentist's office personnel will need the Group and Member identification numbers shown on your Identification Card, as well as your name.

For all claims submitted by you or on your behalf, you will receive a notice (Explanation of Benefits) which shows the amount charged, the amount paid by the program, and, if payment is partially or wholly denied, the reason. The reason is an important factor should you decide to have your claim reviewed.

In many instances, claims are denied or partially paid because information submitted on the claim form is incomplete or incorrect. If denial is based on dental determination, it may be that sufficient information relating to the diagnosis, treatment, etc., was not included on the form. If denial is based on the patient's eligibility, it may be that the Group and Member identification numbers shown on the form are incorrect.

Balance Billing

Participating Providers are prohibited from balance billing. Participating Providers have signed an agreement with BCBSGA to accept our Negotiated Rate for Covered Expenses rendered to a Member who is his or her patient. A Member is not liable for any fee in excess of this Negotiated Rate, except what is due under the Contract, e.g. Copayments, Deductible or Coinsurance.

Processing Your Claim

You are responsible for submitting your claims for expenses not normally billed by and payable to a Dentist.

Always make certain you have your Identification Card with you. Be sure the Dentist's office personnel copies your name, Group and Member identification numbers accurately when completing forms relating to your coverage.

If it is necessary for you to have dental services rendered outside Georgia, it may be necessary for you to pay the attending Dentist for his services and then submit an itemized statement to the BCBSGA office when you return home.

Timeliness of Filing

To receive benefits, a properly completed claim form with any necessary reports and records must be filed within 90 days of the date of service. Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information. In this case, you will be notified within 15 working days of the reason for the delay and will receive a list of all information needed to continue processing your claim. After you return this data, BCBSGA has 15 working days to complete claims processing. BCBSGA shall pay interest at the rate of 18% per year to you or the assigned provider if it does not meet these requirements.

Necessary Information

In order to process your claim, BCBSGA may need information from the provider of the service. As a Member, you agree to authorize the Dentist or other provider to release necessary information.

BCBSGA will consider such information confidential. However, BCBSGA has the right to use this information to defend or explain a denied claim.

Unauthorized Use of Identification Card

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

Questions About Coverage or Claims

If you have questions about your coverage, contact your Plan Administrator or BCBSGA's Customer Service Department. Be sure to always give your Member ID number.

Write

Inquiries should be mailed to P.O. Box 9201, Oxnard, CA 93031. When asking about a claim, give the following information:

- Member ID number;
- Patient name, Subscriber name and address;
- Date of service;
- Type of service received; and
- Provider name and address (Hospital or Physician).

We Want You to be Satisfied

BCBSGA hopes that you will always be satisfied with the level of service provided to you and your family. BCBSGA realizes, however, that there may be times when problems arise and miscommunications occur which lead to feelings of dissatisfaction.

Complaints about BCBSGA Service

As a BCBSGA Member, you have a right to express dissatisfaction and to expect unbiased resolution of issues. The following represents the process established to ensure that BCBSGA gives its fullest attention to your concerns. Please utilize it to tell BCBSGA when you are displeased with any aspect of services rendered.

1. Call the Customer Service Department. The phone number is on your ID Card. Tell us your problem and we will work to resolve it for you as quickly as possible.
2. If you are not satisfied with our answer, you may file a formal complaint, preferably, but not necessarily, in writing. This request for a further review of your concerns should be addressed to the location provided by the Customer Service Representative at the number on your ID Card.
3. If, depending on the nature of your complaint, you remain dissatisfied after receiving our response, you will be offered the right to appeal our decision. At the conclusion of this formalized re-review of your specific concerns, a final written response will be generated to you, which will hopefully bring the matter to a satisfactory conclusion for you.

Summary of Grievances

A summary of the number, nature and outcome results of grievances filed in the previous three years is available for your inspection. You may obtain a copy of any such summary at a reasonable cost from BCBSGA.

Complaints about Provider Service

If your complaint involves care received from a provider, please call the Customer Service number. Your complaint will be resolved in a timely manner.

Terms of Your Coverage

BCBSGA provides the benefits described in this booklet only for eligible Members. The dental services are subject to the limitations, exclusions, Deductibles and percentage payable requirements specified in this booklet. Any group BCBSGA Contract or certificate which you received previously will be replaced by this Contract.

Benefit payment for Covered Services or supplies will be made either directly to the Participating Dentist or to you depending upon whether services were rendered by a Participating or Non-Participating Dentist. You may assign benefits to a Non-Participating Dentist, but it is not required. If you do not assign benefits to a Non-Participating Dentist, any benefit payment will be sent to you.

BCBSGA does not supply you with a Dentist. In addition, BCBSGA is not responsible for any injuries or damages you may suffer due to actions of any provider or other person.

In order to process your claims, BCBSGA may request additional information about the treatment you received and/or other group insurance you may have. This information will be treated confidentially.

An oral explanation of your benefits by a BCBSGA employee is not legally binding.

Any correspondence mailed to you will be sent to your most current address. You are responsible for notifying BCBSGA of your new address.

General Information

Fraudulent statements on Subscriber application forms or data on electronic submissions will invalidate any payment or claims for services and be grounds for voiding the Subscriber's coverage.

Both parties to this Contract (the employer and BCBSGA) are relieved of their responsibilities without breach, if their duties become impossible to perform by acts of God, war, terrorism, fire, etc.

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

Changes in Coverage

Your employer and BCBSGA may mutually agree to change the benefits described in this booklet. Fees charged for benefits described in this booklet may be changed:

- If the level of benefits changes; or
- If the ratio of benefits to fees exceeds an established level.

Acts Beyond Reasonable Control (Force Majeure)

Should the performances 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.

Care Received Outside the United States

You will receive Contract benefits for care and treatment received outside the United States. Contract provisions will apply. Any care received must be a Covered Service. Please pay the provider of service at the time you received treatment and obtain appropriate documentation of services received including bills, receipts, letters and medical and/or dental narrative.

This information should be submitted with your claim. All services will be subject to appropriateness of care. We will reimburse you directly. Payment will be based on Covered Expense for the Member's legal residence. Assignments of benefits to foreign providers or facilities cannot be honored.

Licensed Controlled Affiliate

The Member hereby expressly acknowledges his/her understanding this policy constitutes a contract solely between the Member Group and BCBSGA, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting BCBSGA to use the Blue Cross and Blue Shield Service Marks in the state of Georgia, and that BCBSGA is not contracting as the agent of the Association. The Member Group further acknowledges and agrees that it has not entered into this policy based upon representations by any person other than BCBSGA and that no person, entity, or organization other than BCBSGA shall be held accountable or liable to the Member for any of BCBSGA's obligation to the Member created under this policy. This paragraph shall not create any additional obligations whatsoever on the part of BCBSGA other than those obligations created under other provisions of this agreement.

Governmental Health Care Programs

If you are enrolled in a group with fewer than 20 employees, your benefits will be reduced if you are eligible for coverage (even if you did not enroll) under any federal, state (except Medicaid) or local government health care program.

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 dental plan and receive group benefits as primary coverage.

When Your Coverage Terminates

A. Termination of Coverage (Group)

BCBSGA may cancel this Contract in the event of any of the following:

1. The Group fails to pay Premiums in accordance with the terms of this Contract.
2. The Group performs an act or practice that constitutes fraud or intentional misrepresentation of material fact in applying for or procuring coverage.
3. The Group has fallen below our minimum employer contribution or Group participation rules. We will submit a written notice to the Group and provide the Group 60 days to comply with these rules.
4. We terminate, cancel or non-renew all coverage under a particular policy form, provided that:

    - We provide at least 180 days notice of the termination of the policy form to all Members;
    - We offer the Group all other small Group (employer) or large Group (employer) policies, depending on the size of the Group, currently being offered or renewed by us for which you are otherwise eligible; and
    - We act uniformly without regard to the claims experience or any health status related factor of the individuals insured or eligible to be insured.

B. Termination of Coverage (Individual)

Group program membership for you and your enrolled family members may be continued as long as you are employed by the Group and meet eligibility requirements. It ceases if your employment ends, if you no longer meet eligibility requirements, if the Group Contract 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 in which the child attains age 26. Coverage of a handicapped child over age 26 ceases if the child is found to be no longer totally or permanently disabled. Coverage of the spouse of a Member terminates automatically as of the date of divorce or death.

C. Continuation of Coverage (Georgia Law)

Any Employee insured in Georgia under a company welfare benefit plan whose employment is terminated other than for cause, may be entitled to certain continuation benefits. If you have been continuously enrolled for at least six months under this Contract, or this and its immediately preceding health insurance Contract, you may elect to continue Group health coverage for yourself and your enrolled family members for the rest of the month of termination and three additional months by paying the appropriate Premium.

This benefit entitles each member of your family who is enrolled in the company's Employee welfare benefit plan to elect continuation, independently.

Cost

These continuation benefits are available without proof of insurability at the same Premium rate charged for similarly insured Employees. To elect this benefit you must notify the Group's Plan Administrator within 30 days of the date your coverage would otherwise cease that you wish to continue your coverage and you must pay the required monthly Premiums in advance.

This continuation benefit is not available if:

- your employment is terminated for cause; or
- your health plan enrollment was terminated for your failure to pay a Premium or Premium contribution; or
- your health plan enrollment is terminated and replaced without interruption by another Group Contract; or
- dental insurance is terminated for the entire class of Employees to which you belong; or
- the Group terminates dental insurance for all Employees.

Termination of Benefits

Continuation coverage terminates if you do not pay the required Premium on time or you enroll for other Group insurance or Medicare.

THE FOLLOWING SECTION DOES NOT APPLY TO DOMESTIC PARTNERS.

D. 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, instead of the three months continuation benefit described above, you may elect from 18-36 months of continuation benefits, regardless of whether the Group is insured or self-funded.

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 Employees 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 Employee during the period of continuation coverage is also eligible for election of continuation coverage.

Initial Qualifying Event	Length of Availability of Coverage
For Employees: Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months
For Spouses/ Dependents: A Covered Employee's Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months
Covered Employee's Entitlement to Medicare	36 months
Divorce or Legal Separation	36 months
Death of a Covered Employee	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 can 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 their initial 18 months of COBRA continuation coverage (or 29 months, if the disability provision applies), 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. 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 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.

Continuation of Coverage (Federal Law – 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 Contract, and if he or she 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 this Contract. 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 dental benefits in that the Member and his or her Dependents can elect to continue coverage under this Contract 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 Member returns to work, if the Member meets the requirements specified below, USERRA states that the Employer must waive any exclusions and waiting periods, even if the Member did not elect COBRA continuation. These requirements are (i) the Member 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 Member 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 Member 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). You may also have to provide documentation to the Employer upon reemployment that would confirm eligibility. This protection applies to the Member upon reemployment, as well as to any Dependent who has become covered under this Contract by reason of the Member's reinstatement of coverage.

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. You may also be eligible to receive a tax credit equal to 65% of the cost for health coverage for you and your Dependents charged by the Plan. This tax credit also may be paid in advance directly to the health coverage Provider, reducing the amount you have to pay out-of-pocket.

E. 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. If the other group health plan contains any exclusion or limitation on a pre-existing condition that applies to you, you may continue COBRA coverage only until these limitations cease;
- a covered individual becomes entitled to Medicare after electing COBRA;
- the Group terminates all of its Group welfare benefit plans.

F. Extension of Benefits in Case of Total Disability

If the Group Contract is terminated for non-payment of subscription charges, or if the Group terminates the Contract for any reason, or if the Contract is terminated by us (with 60 days written notice), then in such event the coverage of a totally disabled Subscriber will be as follows:

Contract benefits for the care and treatment of the specific illness, disease or condition that caused the total disability will be extended up to twelve (12) months from the date of termination of the Group Contract or to the maximum of the amount payable under this Contract during the extension period.

NOTE: We consider total disability a condition resulting from disease or Injury where:

- the Member is not able to perform the major duties of his or her occupation and is not able to work for wages or profit; or
- the Member's Dependent is not able to engage in most of the normal activities of a person of the same age and sex.

Definitions

Acceptable Services (also called Covered Services)
Acceptable Services are services and supplies provided in connection with those services which we determine 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
An injury to structures within the oral cavity caused by a traumatic force exterior to the oral cavity. It does not include any injury resulting from biting into food or other substance.

Applicant
The corporation, partnership, sole proprietorship, other organization or Group which applied for this Contract.

Application for Enrollment
The original and any subsequent forms completed and signed by the Subscriber seeking coverage. Such Applications may take the form of an electronic submission.

Benefit Period
One year, January 1 – December 31. Also called calendar year. It does not begin before a Member's Effective Date. It does not continue after a Member's coverage ends.

Certificate
A short written statement which defines BCBSGA's legal obligation to the individual Members. It is part of this Certificate Booklet.

Contract
This Certificate Booklet in conjunction with the Dental Master Contract, the Group Master Contract Application, any amendments or riders, your Identification Card and your Application for Enrollment constitutes the entire Contract. If there is any conflict between either this Certificate Booklet or the Dental Master Contract and any amendment or rider, the amendment or rider shall control. If there is any conflict between this Certificate Booklet and the Dental Master Contract, the Dental Master Contract shall control.

Contract Year
A period of one year commencing on the Effective Date (or renewal date) and ending at 12:00 midnight on the last day of the one year period.

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 dental care or treatment. It avoids claim payment delays by establishing an order in which plans pay their claims and providing 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 or Domestic Partner who meets all the requirements of the Eligibility section of this Certificate Booklet, has enrolled in the program, and is subject to Premium requirements set forth in the Dental Master Contract.

Covered Expense
Covered Expense is the expense the Member incurs for Covered Services but in no event more than:

(1) for Covered Services provided by a Participating Dentist, the Covered Expense will not exceed the Negotiated Rate; and

(2) for Covered Services provided by a Non-Participating Dentist, the Covered Expense is the lesser of the Dentist's actual charge, or the amount BCBSGA has set as reimbursement for that particular service. BCBSGA will set the reimbursement amount at a level that is within the common range of fees billed by a majority of Dentists for a procedure in a given geographic region as follows: (1) we purchase dental claims data from an independent and reliable third party vendor who gathers such information as regular part of its business; (2) such data shows us on a national basis what the majority of Dentists charge in a given area for various services; (3) we will update this third party data for use as the basis of our reimbursement formula as we determine appropriate; and (4) we will use that data to determine allowances for services performed by Non-Participating Dentists which we have determined reasonably reflects the common range of fees charged by a majority of Dentists for a given service in a given geographic region.

Deductible
An amount you must pay each calendar year before BCBSGA will begin to provide benefit payments.

Dentist
A duly licensed Dentist (D.D.S.) or (D.M.D.) legally entitled to practice dentistry at the time and place Covered Services are performed.

Dependent
The spouse, Domestic Partner and all children until attaining age 26. Children include natural children, legally adopted children and stepchildren. Also included are your children (or children of your spouse or Domestic Partner) for whom you have legal responsibility resulting from a valid court decree. Foster children whom you expect to raise to adulthood and who live with you in a regular parent-child relationship are considered children. However, for the purposes of this Contract, a parent-child relationship does not exist between you and a foster child if one or both of the child's natural parents also live with you. In addition, BCBSGA does not consider as a Dependent, welfare placement of a foster child, as long as, the welfare agency provides all or part of the child's support.

Mentally or physically handicapped children remain covered no matter what age. You must give BCBSGA evidence of your child's incapacity within 31 days of attainment of age 26. The certification form may be obtained from BCBSGA or your employer. This proof of incapacity may be required annually by BCBSGA. Such children are not eligible under this Contract if they are already 26 or older at the time coverage is effective.

Domestic Partner
Domestic Partner means your Domestic Partner who meets all the requirements on a Declaration of Domestic Partnership Form. You and your Domestic Partner must submit an accurate and completed Declaration of Partnership Form, and meet all the requirements listed on this form.

Continued eligibility of your Domestic Partner depends upon the continuing accuracy of this form. Domestic Partner eligibility ends on the date a Domestic Partner no longer meets all the requirements listed on this form.

Effective Date

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

Employee

A person who is engaged in active employment with the Group and is eligible for Group coverage with BCBSGA under the employment regulations of the Group.

Experimental or Investigational

Services which are considered Experimental or Investigational include services which (1) have not been approved by the Federal Food and Drug Administration or (2) for which dental and scientific evidence does not demonstrate that the expected benefits of the proposed treatment would be greater than the benefits of any available standard treatment and that adverse risks of the proposed treatment will not be substantially increased over those standard treatments. Such determination must result from prudent professional practices and be supported by at least two documents of dental and scientific evidence. Dental and scientific evidence means:

1. Peer-reviewed scientific studies published in or accepted for publication by dental journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
2. Peer-reviewed literature, biomedical compendia, and other dental literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medikus (EMBASE), Medline, and MEDLARS data base or Health Services Technology Assessment Research (HSTAR);
3. Dental journals recognized by the United States Secretary of Health and Human Services, under Section 18961 (t) (2) of the Social Security Act;
4. The following standard reference compendia: the American Hospital Formulary Service-Drug Information, the American Dental Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;
5. Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, and any national board recognized by the National Institutes of Health for the purpose of evaluating the dental value of health services; or
6. It meets the Technology Assessment Criteria as determined by BCBSGA as outlined in the Definitions section of this Certificate Booklet.

Group

The Subscriber's employer, which has entered the Dental Master Contract with BCBSGA. The Group shall act only as an agent of Members who are Subscribers of the Group and their eligible Dependents.

Identification Card

The latest card given to you showing your Member and Group numbers, the type coverage you have and the date the coverage became effective.

Initial Enrollee
A person actively employed by the Group (or one of that person's eligible Dependents) on the original Effective Date of the Dental Master Contract between BCBSGA and the Group or currently enrolled through the Group under a BCBSGA Contract.

MCSO-Medical Child Support Order
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 health benefits with respect to the child of a Group health plan participant or requires health 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 health plan.

Medically Necessary
Procedures, supplies, equipment or services that are considered to be:
1. appropriate for the symptoms, diagnosis, or treatment of a dental condition, and
2. provided for the diagnosis or direct care and treatment of the dental condition, and
3. within the standards of good dental practice within the organized dental community, and
4. not primarily for the convenience of the Member's Dentist or another provider, and
5. the most appropriate procedure, supply, equipment or service must satisfy the following requirements:
    - there must be valid scientific evidence demonstrating that the expected health (or dental) benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for the patient with the particular dental condition being treated than other possible alternative; and
    - generally, accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable.

Important Notice – The fact that a Dentist may prescribe, order, recommend or approve a procedure, treatment, supply or device does not, in and of itself, make it Medically Necessary or make the charge a Covered Expense under the Contract, even if it has not been listed as an exclusion.

BCBSGA will determine, at its discretion, whether a procedure, treatment, supply or device is Medically Necessary.

Medicare and Medicaid
Reference to "Medicare" means the health insurance for the aged and disabled provided by the United States Social Security Act. The term "Medicaid" means health benefits for the needy provided by states under requirements of the United States Social Security Act.

Member
The Subscriber and each Dependent, as defined in this booklet, while such person is covered by this Contract.

Negotiated Rate
The Negotiated Rate is the rate of payment for Services that BCBSGA 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 Group on the original Effective Date of the Dental Master Contract.

Non-Covered Services
Services that are not benefits specifically provided under the Contract, are excluded by the Contract, or are otherwise not eligible to be Covered Services, whether or not they are Acceptable Services.

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

Participating Provider
A Dentist or Physician who has in effect a Participating Agreement with BCBSGA 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.

Physician
Any licensed Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery and any licensed Doctor of Dental Surgery (D.D.S.) legally entitled to perform oral surgery.

Plan Administrator
The person named by your employer to manage the program and answer questions about program details.

Premium
The amount that the Group or Member is required to pay BCBSGA to continue coverage.

QMCSO – Qualified 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 health 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.

Reasonable and Customary Level
A charge which is the usual charge made to persons in the same general locality for similar services or supplies. **Important Notice** – BCBSGA may rely upon cost data and the advice of dental peer review groups and other dental experts to determine the Reasonable and Customary Level. The determination of the Reasonable and Customary Level will be made by BCBSGA.

Subscriber
The individual who signed the Application for Enrollment and in whose name the Identification Card is issued.

Technology Assessment Criteria
Five criteria all procedures must meet in order to be Covered Services under this Contract.
1. the technology must have final approval from the appropriate government regulatory bodies.
2. the scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
3. the technology must improve the net health (or dental) outcome.
4. the technology must be as beneficial as any established alternative.
5. the technology must be beneficial in practice.

Statement of ERISA Rights

General Information About ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) entitles you, as a Member of the Group under this Contract, to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by this plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions;
2. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies; and
3. Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for you and other Employees, ERISA imposes duties on the people responsible for the operation of your Employee benefit plan. The people who operate your plan are called plan fiduciaries. They must handle your plan prudently and in the best interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your right under ERISA. If your claim for welfare benefits is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claims reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide you the materials and pay you up to $110 a day until you receive the materials, unless the materials are not sent because of reasons beyond the control of the Plan Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. If plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. It may order you to pay these expenses, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Claims Disclosure Notice

This Certificate Booklet contains information on reporting claims, including the time limitations on submitting a claim. Claim forms may be obtained from the Plan Administrator or BCBSGA. In addition to this information, if this *plan* is subject to ERISA, ERISA applies some additional claim procedure rules. The additional rules required by ERISA are set forth below. To the extent that the ERISA claim procedure rules are more beneficial to you, they will apply in place of any similar claim procedure rules included in this Certificate Booklet.

Urgent Care. BCBSGA must notify you, within 72 hours after receiving your request for benefits, that the request has been received and what your benefits are determined to be. If your request for benefits does not contain all the necessary information, BCBSGA must notify you within 24 hours after receiving it and tell you what information is missing. Any notice to you by

BCBSGA will be orally by telephone or in writing by facsimile or other fast means. You have at least 48 hours to give BCBSGA the additional information needed to process your request for benefits. You may give BCBSGA the additional information needed orally by telephone or in writing by facsimile or other fast means.

If your request for benefits is denied in whole or in part, you will receive a notice of the denial within 72 hours after BCBSGA's receipt of the request for benefits or 48 hours after receipt of all the information needed to process your request for benefits, if the information is received in a timely manner as stated above. The notice will explain the reason for the denial and the plan provision upon which the decision is based. You have 180 days to appeal the decision. You may appeal the decision orally by telephone or in writing by facsimile or other fast means. Within 72 hours after BCBSGA receives your appeal, if your claim is still considered urgent under the circumstances at the time of the appeal, BCBSGA must notify you of the decision. BCBSGA will notify you orally by telephone or in writing by facsimile or other fast means. If your claim is no longer considered urgent, it will be handled in the same manner as a Non-Urgent Care Pre-Service or Post-Service appeal, depending upon the circumstances.

Non-Urgent Care Pre-Service (when care has not yet been received). BCBSGA must notify you, within 15 days after receiving your request for benefits, that the request has been received and what your benefits are determined to be. If BCBSGA needs more than 15 days to determine your benefits, due to reasons beyond BCBSGA's control, BCBSGA must notify you within that 15-day period that more time is needed to determine your benefits. But, in any case, even with an extension, BCBSGA cannot take more than 30 days to determine your benefits. If you do not properly submit all the necessary information for your claim, BCBSGA must notify you, within 5 days after receiving it and tell you what information is missing. You have 45 days to provide BCBSGA with the information needed to process your request for benefits. The time period during which BCBSGA is waiting for receipt of the necessary information is not counted toward the time frame in which BCBSGA must make the benefit determination.

If your claim is denied in whole or in part, you will receive a written notice of the denial within the time frame noted above after BCBSGA has all the information needed to process your request for benefits, if the information is received in a timely manner as stated above. The written notice will explain the reason for the denial and the plan provisions upon which the decision was made. You have 180 days to appeal an adverse benefit determination. Your appeal must be in writing. Within 30 days after a pre-service appeal is received, BCBSGA must notify you of the decision. BCBSGA's notice of the decision will be in writing.

Concurrent Care Decisions. If, after approving a request for benefits in connection with your illness or Injury, BCBSGA decides to reduce or end the benefits that had been approved for you, in whole or in part:

- BCBSGA must notify you sufficiently in advance of the reduction in benefits, or the end of benefits, to allow you the opportunity to appeal the decision before the reduction in benefits or end of benefits occurs. In the notice to you, BCBSGA must explain the reason for reducing or ending your benefits and the plan provisions upon which the decision was made.

- To keep the benefits you already have approved, you must successfully appeal the decision to reduce or end those benefits. You must make your appeal to BCBSGA at least 24 hours prior to the occurrence of the reduction or ending of benefits. If you appeal the decision to reduce or end your benefits when there is less than 24 hours to the occurrence of the reduction or ending of benefits, your appeal will be treated as if you were appealing a non-urgent care denial of benefits (see “Urgent Care” above).

- If your appeal for benefits is received at least 24 hours prior to the occurrence of the reduction or ending of benefits, BCBSGA must notify you of the decision regarding your appeal within 72 hours of the receipt of your appeal. If your appeal of the decision to reduce or end your benefits is denied, in whole or in part, BCBSGA must explain the reason for the

denial of benefits and the plan provisions upon which the decision was made. You may further appeal the denial of benefits according to the rules for appeal of an urgent care denial of benefits (see "Urgent Care" above).

Non-Urgent Care Post-Service (reimbursement for cost of dental care). BCBSGA must notify you, within 30 days after receiving your request for benefits, that the request has been received and what your benefits are determined to be. (In order to comply with Georgia law, BCBSGA will address claims for services already rendered within 15 business days of receipt.) If more than 30 days are needed to determine your benefits, due to reasons beyond BCBSGA's control, BCBSGA must notify you within that 30-day period that more time is needed to determine your benefits. But, in any case, even with an extension, BCBSGA cannot take more than 45 days to determine your benefits. If you do not submit all the necessary information for your claim, BCBSGA must notify you, within 30 days after receiving it and tell you what information is missing. You have 45 days to provide the information needed to process your claim. The time period during which BCBSGA is waiting for receipt of the necessary information is not counted toward the time frame in which BCBSGA must make the benefit determination.

If your claim is denied in whole or in part, you will receive a written notice of the adverse benefit determination within the time frame stated above after BCBSGA has all the information needed to process your request for benefits, if the information is received within the time frame noted above. The written notice will explain the reason for the adverse benefit determination and the plan provisions upon which the decision was made. You have 180 days to appeal the adverse benefit determination. Your appeal must be in writing. Within 60 days after receiving your appeal, BCBSGA must notify you of the decision. The notice to you of the decision will be in writing.

Note: You, your beneficiary, or a duly authorized representative may appeal any denial of a claim for benefits with BCBSGA and request a review of the adverse benefit determination. In connection with such a request, documents pertinent to the administration of the plan may be reviewed free of charge; and issues outlining the basis of the appeal may be submitted. You may have representation throughout the appeal and review procedure.

Dental information BCBSGA has regarding your case will be released to you or an attorney only by written authorization from your Provider and/or the Hospital.

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