VOLUNTARY DENTAL BENEFIT PROGRAM

Plan 7500DV

COLUMBUS CONSOLIDATED GOVERNMENT

F-1681.722-001 09/2010

CERTIFICATE OF COVERAGE

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

Voluntary Dental Master Contract

To
COLUMBUS CONSOLIDATED GOVERNMENT
(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 which 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.

C. Morgan Kendrick,
President

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SCHEDULE OF BENEFITS

Your amounts of personal and Dependent insurance are determined by this schedule. You are not insured for any type of coverage for which this Schedule of Benefits form shows the amount as "none".

All benefits payable are subject to the provisions, limitations and exclusions contained in the group policy. If you receive services or supplies from a Participating Provider, any billed amount above Covered Expense will be a savings to you. Participating Providers have agreed to accept the Negotiated Rate as payment in full. Non-Participating Providers have no such agreement with BCBSGA, therefore, they will bill you for any amounts over Covered Expense. This means your share of the cost for your dental care may be greater if you choose a Non-Participating Provider.

Summary of Benefits	
Yearly Maximum Maximum per calendar year per Member based on Covered Expense	$1,000
Calendar Year Deductible Individual Family The first three Members of an enrolled family to satisfy their Deductible will satisfy the Deductible for the entire family.	$50 $150
Percentage Payable All payments are based on Covered Expense.	
Type 1 - Preventive and Diagnostic Services Participating Provider Non-Participating Provider	100%* Based on Fee Schedule
Type 2 - Basic Services Participating Provider Non-Participating Provider	50%* Based on Fee Schedule
Type 3 - Major Services Participating Provider Non-Participating Provider	50%* Based on Fee Schedule
Benefit Waiting Periods	
Type 1 - Preventive and Diagnostic Services	0 Months
Type 2 - Basic Services	0 Months
Type 3 - Major Services (Oral Surgery)	6 Months
Type 3 -Other Major Services (Including: Endodontics, Periodontics, Prosthodontics)	12 Months

*****Based on Negotiated Rate

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 Group's current Contract 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 or husband (spouse);
- 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) 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.

Please note: For the purpose of this Contract, a spouse is the Subscriber's legal spouse as recognized by the state in which you live.

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

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.

Late Applicants
If You do not apply for Dental benefits within the first 31 days after You become eligible, You and your Dependents will be considered Late Applicants.

If your Dependent child is not enrolled within the first 31 days after becoming eligible and before the age of 2 years, this Late Applicant provision will apply.

After this Dental Coverage becomes effective, as a Late Applicant, You have coverage as follows:

- **Type 1 Preventive:** immediately.
- **Type 2 Basic:** immediately.
- **Type 3 Major Oral Surgery:** following 6 consecutive months of coverage.
- **Type 3 Other Major:** Endodontics, Periodontics, Prosthodontics: following 12 consecutive months of coverage.

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)

As your family increases, you may add new Dependents 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 Major Services and a 6-month waiting period for Oral Surgery.

Newborn and Adopted Children

A newborn or and 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 Major Services and a 6-month waiting period for Oral Surgery.

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 have a 12-month waiting period for Major Services and a 6-month waiting period for Oral Surgery.

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 of 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 due to disability from illness or injury 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.

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.
This dental Contract provides for the least expensive professionally adequate treatment. This provision does not change the plan of treatment, but establishes a benefit allowance toward service upon which patient and Dentist agree.
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.

COVERED PROCEDURES

The following is a sample listing of Covered Services, their assigned procedure class or procedure type, waiting period, and applicable limitations. If the dental service you are receiving is not indicated below, you may telephone our dental customer service department toll free at the telephone number indicated on your identification card for more information. The payment of benefits is subject to all provisions of this Certificate.

Please see the Key for Benefits following the list of Covered Services for applicable Procedure Type, Benefit Waiting Period and Limitations.

PROCEDURE FEE SCHEDULE –

KEY FOR BENEFITS

*** Procedure Type**

1 Preventive
2 Basic
3 Major Oral Surgery
3 Other Major

**** Benefit Waiting Periods**

(i) None
(ii) None
(iii) 6 months
(iv) 12 months

Procedure Code	Procedure Description	*Procedure Type	**Benefit Waiting Period Months	See Limitations
Exams				
D0120	Periodic Oral Evaluation	1	0	(u)
D0140	Limited Oral Evaluation - Problem Focused	2	0	(u)
D0150	Comprehensive Oral Evaluation	1	0	(u)
D0180	Comprehensive periodontal evaluation - new or established patient	1	0	(u)
Radiographs – Bitewings				
D0220	Intraoral - Periapical - First Film	1	0	(q)
D0230	Intraoral - Periapical - Each additional Film	1	0	(q)
D0240	Intraoral - Occlusal Film	1	0	(q)
D0250	Extraoral - First Film	1	0	(q)
D0260	Extraoral - Each additional Film	1	0	(q)
D0270	Bitewing - Single Film	1	0	(q) (p)
D0272	Bitewings - Two Films	1	0	(q) (p)
D0274	Bitewings - Four Films	1	0	(q) (p)
D0277	Vertical Bitewings	1	0	(v) (q) (p)
Radiographs – FMX				
D0210	Intraoral - Complete Series (including Bitewings)	2	0	(y)
D0330	Panoramic Film	2	0	(y)
Cleanings				
D1110	Prophylaxis - Adult	1	0	(a)
D1120	Prophylaxis - Child	1	0	(a)
Fluoride				
D1201	Topical Application of Fluoride (including Prophylaxis) - Child	1	0	(a) (c) (d)
D1203	Topical Application of Fluoride (Prophylaxis not included) - Child	1	0	(c) (d)
Sealants				
D1351	Sealant - per tooth	2	0	(g)
Space Maintainers				
D1510	Space Maintainer - Fixed - Unilateral	1	0	(w) (bb)
D1515	Space Maintainer - Fixed - Bilateral	1	0	(w) (bb)
D1520	Space Maintainer - Removable - Unilateral	1	0	(w) (bb)

Procedure Code	Procedure Description	*Procedure Type	**Benefit Waiting Period Months	See Limitations
Space Maintainers (cont'd)				
D1525	Space Maintainer - Removable - Bilateral	1	0	(w) (bb)
D1550	Recementation of Space Maintainer	1	0	(w) (bb)
Palliative Treatment				
D9110	Palliative (emergency) treatment of dental pain - minor procedure	2	0	(d)
Fillings				
D2140	Amalgam - One surface, primary or permanent	2	0	(o) (i)
D2150	Amalgam - Two surfaces, primary or permanent	2	0	(o) (i)
D2160	Amalgam - Three surfaces, primary or permanent	2	0	(o) (i)
D2161	Amalgam - Four or more surfaces, primary or permanent	2	0	(o) (i)
D2330	Resin - One surface, Anterior	2	0	(o) (i)
D2331	Resin - Two surfaces, Anterior	2	0	(o) (i)
D2332	Resin - Three surfaces, Anterior	2	0	(o) (i)
D2335	Resin - Four or more surfaces or involving incisal angle (Anterior)	2	0	(o) (i)
D2391	Resin-based composite - one surface, posterior	2	0	(o) (i)
D2392	Resin-based composite - two surfaces, posterior	2	0	(o) (i)
D2393	Resin-based composite - three surfaces, posterior	2	0	(o) (i)
D2394	Resin-Based composite - four or more surfaces, posterior	2	0	(o) (i)
Single Tooth Restorations				
D2510	Inlay - Metallic - One surface	3	12	(cc) (dd)
D2720	Crown - Resin with High Noble Metal	3	12	(cc) (dd)
D2721	Crown - Resin with Predominantly Base Metal	3	12	(cc) (dd)
D2750	Crown - Porcelain Fused to High Noble Metal	3	12	(cc) (dd)
D2751	Crown - Porcelain Fused to Predominantly Base Metal	3	12	(cc) (dd)
D2780	Crown-3/4 Cast High Noble metal	3	12	(cc) (dd)
D2781	Crown - 3/4 Cast High predominantly Base Metal	3	12	(cc) (dd)
D2920	Recement Crown	3	12	(z)
D2930	Prefabricated Stainless Steel Crown - Primary tooth	3	12	(cc) (w)
D2950	Core Buildup, including any pins	3	12	(cc) (dd)
Endodontics				
D3220	Therapeutic Pulpotomy (excluding final restoration)	3	12	
D3310	Anterior (excluding final restoration)	3	12	(s)
D3320	Bicuspid (excluding final restoration)	3	12	(s)
D3330	Molar (excluding final restoration)	3	12	(s)
D3346	Retreatment of previous Root Canal Therapy - Anterior	3	12	(s)
D3347	Retreatment of previous Root Canal Therapy - Bicuspid	3	12	(s)
D3348	Retreatment of previous Root Canal Therapy - Molar	3	12	(s)
D3410	Apicoectomy/Periradicular Surgery - Anterior	3	12	(r)
D3421	Apicoectomy/Periradicular Surgery - Bicuspid (first root)	3	12	(r)
D3425	Apicoectomy/Periradicular Surgery - Molar (first root)	3	12	(r)
D3920	Hemisection (including any root removal), not including Root Canal Therapy	3	12	(s)

Procedure Code	Procedure Description	*Procedure Type	**Benefit Waiting Period Months	See Limitations
Periodontics				
D4210	Gingivectomy or Gingivoplasty - per quadrant	3	12	(k)
D4260	Osseous Surgery (including Flap Entry and Closure) - per quadrant	3	12	(n)
D4341	Periodontal Scaling and Root Planing, per quadrant	3	12	(k)
D4355	Full Mouth Debridement to enable Comprehensive Periodontal evaluation and Diagnosis	3	12	(m)
D4910	Periodontal Maintenance Procedures (following active therapy)	3	12	(a)
Removable Prosthodontics				
D5110	Complete Denture - Maxillary	3	12	(i)
D5120	Complete Denture - Mandibular	3	12	(i)
D5211	Maxillary Partial Denture - Resin Base (including any conventional clasps, rests and teeth)	3	12	(i)
D5212	Mandibular Partial Denture - Resin Base (including any conventional clasps, rests and teeth)	3	12	(i)
Prosthodontics Repairs				
D5410	Adjust Complete Denture - Maxillary	3	12	(d) (z)
D5411	Adjust Complete Denture - Mandibular	3	12	(d) (z)
D5421	Adjust Partial Denture - Maxillary	3	12	(d) (z)
D5422	Adjust Partial Denture - Mandibular	3	12	(d) (z)
D5510	Repair broken Complete Denture Base	3	12	(d) (z)
D5710	Rebase Complete Maxillary Denture	3	12	(f) (z)
D5711	Rebase Complete Mandibular Denture	3	12	(f) (z)
D5720	Rebase Maxillary Partial Denture	3	12	(f) (z)
D5721	Rebase Mandibular Partial Denture	3	12	(f) (z)
D5730	Reline Complete Maxillary Denture (chairside)	3	12	(f) (z)
D5731	Reline Complete Mandibular Denture (chairside)	3	12	(f) (z)
D5740	Reline Maxillary Partial Denture (chairside)	3	12	(f) (z)
D5741	Reline mandibular Partial Denture (chairside)	3	12	(f) (z)
D5851	Tissue Conditioning, Mandibular	3	12	(j) (z)
Fixed Prosthodontics				
D6210	Pontic - Cast High Noble Metal	3	12	(cc) (dd)
D6211	Pontic - Cast Predominantly Base Metal	3	12	(cc) (dd)
D6240	Pontic - Porcelain fused to High Noble Metal	3	12	(cc) (dd)
D6241	Pontic - Porcelain fused to Predominantly Base Metal	3	12	(cc) (dd)
D6250	Pontic - Resin with High Noble Metal	3	12	(cc) (dd)
D6251	Pontic - Resin with Predominantly Base Metal	3	12	(cc) (dd)
D6720	Crown - Resin with High Noble Metal	3	12	(cc) (dd)
D6721	Crown - Resin with Predominantly Base Metal	3	12	(cc) (dd)
D6750	Crown - Porcelain fused to High Noble Metal	3	12	(cc) (dd)
D6751	Crown - Porcelain fused to Predominantly Base Metal	3	12	(cc) (dd)
D6780	Crown - 3/4 Cast High Noble Metal	3	12	(cc) (dd)
D6781	Crown - 3/4 Cast Predominately Based Metal	3	12	(cc) (dd)
D6930	Recement Fixed Partial Denture	3	12	(d) (z)

Procedure Code	Procedure Description	*Procedure Type	**Benefit Waiting Period Months	See Limitations
Simple Extractions				
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	3	6	
Oral Surgery				
D7220	Removal of Impacted tooth - Soft Tissue	3	6	(b)
D7230	Removal of Impacted tooth - Partially Bony	3	6	(b)
D7240	Removal of Impacted tooth - Completely Bony	3	6	(b)
D7310	Alveoloplasty in conjunction with Extractions - per quadrant	3	6	(e)
D7320	Alveoloplasty not in conjunction with Extractions - per quadrant	3	6	(e)
D7960	Frenulectomy (Frenectomy or Frenotomy) - separate procedure	3	6	(e)
Anesthesia				
D9220	General Anesthesia - first 30 minutes	3	0	(t)
D9221	General Anesthesia - each additional 15 minutes	3	0	(t)

Limitations

(a) Prophylaxis or periodontal prophylaxis treatments, singly or in combination, not to exceed two treatments per year.	(p) Limited to 2 bite wing x-ray series for standard in a calendar year
(b) Extraction of third molars (wisdom teeth) if the patient is under the age of 16 is not covered	(q) Periapical and bite wing x-rays submitted singly will be combined and paid up to the amount of a full mouth series
(c) Limited to Dependent Children under age 19	(r) Maximum 1 time per tooth
(d) Maximum of 1 procedure per 12 months	(s) Maximum of 1 per tooth per lifetime
(e) Maximum of 1 per lifetime, per quad or arch	(t) Only in conjunction with complex oral surgery procedures and subject to review
(f) Maximum of 1 procedure per 24 months	(u) Limited to 2 oral evaluation procedures, in any combination per calendar year
(g) Limited to covered dependent children between the ages of 6 and 15 years, once per tooth for unrestored permanent first and second molars every 3 years).	(v) Limited to 8 films for vertical bite wings in a 60 month period
(h) Maximum of 1 per 7 year period	(w) Limited to dependent children under age 16
(i) Maximum of 1 per 5 year period	(x) Limited to 1 oral evaluation procedure, in any combination per calendar year
(j) Maximum of 1 each quadrant per 12 months	(y) Limited to one set of full-mouth x-rays or the equivalent in a 60 month period
(k) Maximum of 1 each quadrant per 24 months	(z) 6 months must have passed since initial placement
(l) Maximum of 1 each tooth per 24 months	(aa) Maximum of 1 per tooth per 7 year period
(m) Allowed one time at the beginning of a Periodontal treatment plan, prior to pocket depth charting. Subsequent requirement for debridement is considered patient neglect and would be the financial responsibility of the Insured	(bb) Limited to once per lifetime including 1 adjustment within 6 months of placement
(n) Maximum of 1 each quadrant per 36 months	(cc) Maximum of 1 per tooth per 5 year period
(o) Replacement of existing only if in place for 24 months	(dd) Limited to patients age 16 and over

MAXIMUM BENEFIT SCHEDULE

Below is a sample listing of the Maximum Benefits for Covered Services. If the services you are receiving are not indicated below or if you need assistance in determining the Maximum Benefit for any service provided by a Dentist, you may telephone our dental customer service department toll free at the telephone number indicated on your identification card for more information.

Remember that the Maximum Benefit may be less than the Non-participating Provider charges for his or her services. You are responsible to pay any charge by the Non-participating Provider that exceeds Covered Expense.

Covered Expense will not exceed the following **Maximum Benefit** schedule for services provided by a Non-contracting Provider:

Procedure Code	Procedure Description	Plan Pays
Exams		
D0120	Periodic Oral Evaluation	$15
D0140	Limited Oral Evaluation - Problem Focused	$23
D0150	Comprehensive Oral Evaluation	$23
D0180	Comprehensive periodontal evaluation - new or established patient	$25
Radiographs – Bitewings		
D0220	Intraoral - Periapical - First Film	$8
D0230	Intraoral - Periapical - Each additional Film	$6
D0240	Intraoral - Occlusal Film	$11
D0250	Extraoral - First Film	$17
D0260	Extraoral - Each additional Film	$10
D0270	Bitewing - Single Film	$8
D0272	Bitewings - Two Films	$13
D0274	Bitewings - Four Films	$19
D0277	Vertical Bitewings	$27
Radiographs – FMX		
D0210	Intraoral - Complete Series (including Bitewings)	$33
D0330	Panoramic Film	$27
Cleanings		
D1110	Prophylaxis - Adult	$29
D1120	Prophylaxis - Child	$20

Procedure Code	Procedure Description	Plan Pays
Fluoride		
D1201	Topical Application of Fluoride (including Prophylaxis) - Child	$30
D1203	Topical Application of Fluoride (Prophylaxis not included) - Child	$11
Sealants		
D1351	Sealant - per tooth	$16
Space Maintainers		
D1510	Space Maintainer - Fixed - Unilateral	$104
D1515	Space Maintainer - Fixed - Bilateral	$163
D1520	Space Maintainer - Removable - Unilateral	$129
D1525	Space Maintainer - Removable - Bilateral	$188
D1550	Recementation of Space Maintainer	$21
Palliative Treatment		
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$28
Fillings		
D2140	Amalgam - One surface, primary or permanent	$32
D2150	Amalgam - Two surfaces, primary or permanent	$40
D2160	Amalgam - Three surfaces, primary or permanent	$48
D2161	Amalgam - Four or more surfaces, primary or permanent	$58
D2330	Resin - One surface, Anterior	$37
D2331	Resin - Two surfaces, Anterior	$45
D2332	Resin - Three surfaces, Anterior	$57
D2335	Resin - Four or more surfaces or involving incisal angle (Anterior)	$66
D2391	Resin-based composite - one surface, posterior	$42
D2392	Resin-based composite - two surfaces, posterior	$55
D2393	Resin-based composite - three surfaces, posterior	$69
D2394	Resin-Based composite - four or more surfaces, posterior	$84
Single Tooth Restorations		
D2510	Inlay - Metallic - One surface	$135
D2720	Crown – Resin with High Noble Metal	$169
D2721	Crown – Resin with Predominantly Base Metal	$146
D2750	Crown – Porcelain Fused to High Noble Metal	$177
D2751	Crown – Porcelain Fused to Predominantly Base Metal	$154
D2780	Crown-3/4 Cast High Noble metal	$180
D2781	Crown – 3/4 Cast High predominantly Base Metal	$182
D2920	Recement Crown	$16
D2930	Prefabricated Stainless Steel Crown – Primary tooth	$40
D2950	Core Buildup, including any pins	$41

Procedure Code	Procedure Description	Plan Pays
Endodontics		
D3220	Therapeutic Pulpotomy (excluding final restoration)	$26
D3310	Anterior (excluding final restoration)	$119
D3320	Bicuspid (excluding final restoration)	$141
D3330	Molar (excluding final restoration)	$177
D3346	Retreatment of previous Root Canal Therapy – Anterior	$157
D3347	Retreatment of previous Root Canal Therapy – Bicuspid	$178
D3348	Retreatment of previous Root Canal Therapy – Molar	$208
D3410	Apicoectomy/Periradicular Surgery – Anterior	$135
D3421	Apicoectomy/Periradicular Surgery – Bicuspid (first root)	$147
D3425	Apicoectomy/Periradicular Surgery – Molar (first root)	$161
D3920	Hemisection (including any root removal), not including Root Canal Therapy	$68
Periodontics		
D4210	Gingivectomy or Gingivoplasty – per quadrant	$100
D4260	Osseous Surgery (including Flap Entry and Closure) – per quadrant	$188
D4341	Periodontal Scaling and Root Planning, per quadrant	$41
D4355	Full Mouth Debridement to enable Comprehensive Periodontal evaluation and Diagnosis	$26
D4910	Periodontal Maintenance Procedures (following active therapy)	$23
Removable Prosthodontics		
D5110	Complete Denture - Maxillary	$208
D5120	Complete Denture - Mandibular	$208
D5211	Maxillary Partial Denture - Resin Base (including any conventional clasps, rests and teeth)	$170
D5212	Mandibular Partial Denture - Resin Base (including any conventional clasps, rests and teeth)	$188
Prosthodontics Repairs		
D5410	Adjust Complete Denture - Maxillary	$13
D5411	Adjust Complete Denture - Mandibular	$12
D5421	Adjust Partial Denture - Maxillary	$14
D5422	Adjust Partial Denture - Mandibular	$13
D5510	Repair broken Complete Denture Base	$27
D5710	Rebase Complete Maxillary Denture	$81

Procedure Code	Procedure Description	Plan Pays
Prosthodontics Repairs (cont'd)		
D5711	Rebase Complete Mandibular Denture	$83
D5720	Rebase Maxillary Partial Denture	$77
D5721	Rebase Mandibular Partial Denture	$83
D5730	Reline Complete Maxillary Denture (chairside)	$50
D5731	Reline Complete Mandibular Denture (chairside)	$47
D5740	Reline Maxillary Partial Denture (chairside)	$47
D5741	Reline mandibular Partial Denture (chairside)	$47
D5851	Tissue Conditioning, Mandibular	$25
Fixed Prosthodontics		
D6210	Pontic - Cast High Noble Metal	$167
D6211	Pontic - Cast Predominantly Base Metal	$156
D6240	Pontic - Porcelain fused to High Noble Metal	$175
D6241	Pontic - Porcelain fused to Predominantly Base Metal	$151
D6250	Pontic - Resin with High Noble Metal	$177
D6251	Pontic - Resin with Predominantly Base Metal	$156
D6720	Crown - Resin with High Noble Metal	$174
D6721	Crown - Resin with Predominantly Base Metal	$146
D6750	Crown - Porcelain fused to High Noble Metal	$177
D6751	Crown - Porcelain fused to Predominantly Base Metal	$155
D6780	Crown - 3/4 Cast High Noble Metal	$166
D6781	Crown - 3/4 Cast Predominately Based Metal	$187
D6930	Recement Fixed Partial Denture	$22
Simple Extractions		
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$37
Oral Surgery		
D7220	Removal of Impacted tooth - Soft Tissue	$50
D7230	Removal of Impacted tooth - Partially Bony	$63
D7240	Removal of Impacted tooth - Completely Bony	$73
D7310	Alveoloplasty in conjunction with Extractions - per quadrant	$40
D7320	Alveoloplasty not in conjunction with Extractions - per quadrant	$83
Anesthesia		
D9220	General Anesthesia - first 30 minutes	$59
D9221	General Anesthesia - each additional 15 minutes	$21

Deductible

You must satisfy the Deductible amount as shown in the **Summary of Benefits** each calendar year for dental expenses.

Each Member must meet a Deductible amount of $50 for Covered Expenses during a calendar Year. The first three Members of an enrolled family to satisfy their Deductible will satisfy the Deductible for the entire family. Once the family Deductible is satisfied, no further Deductible is required for the remainder of that Year.

The Calendar Year Deductible is applied on a combined family Deductible basis. The family Deductible maximum is 3 times the Individual Deductible shown in the Summary of Benefits. The combined total family Deductible is determined as follows: The Individual Deductible is shown in the Summary of Benefits. The Family Deductible is satisfied when 3 times that Individual Deductible has been met, with no one individual contributing more than the Individual Deductible amount. This combined Family Deductible is shown in the Summary of Benefits.

If your Deductible is not met in a given year, Covered Expense incurred from October through December and applied toward the Deductible for that Year will also be applied toward your Deductible for the next Year. If any portion of your Deductible is satisfied prior to October in a given year, BCBSGA will not carry over any amount applied toward Deductible to the next Year's Deductible.

There is a combined Deductible for Preventive, Basic and Major Services.

Pre-Determination of Benefits

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

Orthodontic Services are excluded from this dollar maximum. BCBSGA reserves the right to request X-rays on other services on an as needed basis.

When BCBSGA has reviewed the claim and determined the benefits payable, the approved benefits are indicated on the claim and returned to the Dentist. In this manner, the Dentist and the patient know how much coverage is available before the services are performed.

When the services have been completed, the Dentist resubmits the same claim with completed dates of service to BCBSGA. Please be certain to have your Member and Group numbers, as shown on your Identification Card, so your Dentist's office can copy this information accurately.

What's Not Covered by your Dental Contract

1. Services for which the Member incurs no charge.
2. Dental service which is the result of an injury or disease for which you are entitled to benefits, in whole or in part, under Workers' Compensation or employer's liability laws.
3. Dental services with respect to congenital tooth malformations or primarily for cosmetic or esthetic purposes unless due to Accidental Injury sustained while you are covered under this Contract.
4. Treatment furnished or available to you in whole or in part under the laws of the United States, or any state, or political subdivision.
5. 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.
6. Diagnosis or treatment of the joint of the jaw and/or occlusion services, supplies or appliances provided in connection with: any treatment to alter, correct, fix improve, remove, replace reposition, restore or otherwise treat the joint of the jaw or associated musculature, nerves and other tissues for any reason or by any means; or any treatment, including crowns or bridges to change the way the upper and lower teeth meet (occlusion); or treatment to change vertical dimension (the space between the upper and lower jaw) for any reason or by any means including the restoration of vertical dimension because teeth have worn down.
7. Gold foil restorations.
8. Treatment needed because of diseases contracted, or injuries sustained, as a result of war.
9. Any procedure started while you were not insured under this Contract.
10. Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are, in BCBSGA's judgment, Experimental or Investigational for the diagnosis for which the Member is being treated. An Experimental or Investigational service is not made eligible for coverage by the fact that other treatment is considered by a Member's Physician or Dentist to be ineffective or not as effective as the service or that the service is prescribed as the most likely to prolong life.
11. The replacement of a crown, inlay or onlay within five (5) years of the date of last placement, unless such replacement is required as a result of Accidental Injury sustained while you are covered under this Contract.
12. Replacement of a partial denture, full denture, or fixed bridge (including a Maryland bridge) or the addition of teeth to a partial denture unless:
    - Replacement occurs at least 5 years after the initial date of insertion of the current full or partial denture or Maryland bridge; or
    - Replacement occurs at least 5 years after the initial date of insertion of an existing fixed bridge; or
    - The replacement prosthesis or the addition of a tooth to a partial denture is required by the Necessary extraction of a functioning natural tooth while the Covered Person was covered by this Dental Benefit Plan, provided that tooth was not an abutment to an existing partial denture or Maryland Bridge that is less than 5 years old or to an existing fixed bridge that is less than 5 years old; or
    - The replacement is required as a result of Accidental Injury sustained while you are covered under this Contract.
13. Periodontal splinting (intracoronal and extracoronal).
14. Charges for education or training in and supplies used for dietary or nutritional counseling, personal oral hygiene or dental plaque control.
15. Implants and related services.
16. Dental services for which coverage is available to you under any other group (medical/surgical) contract issued by the BCBSGA, a participating plan or any other carrier.
17. Charges for treatment by other than a Dentist, except for services rendered by a dental hygienist under the direct supervision of a Dentist.

18. Charges for services or supplies that are cosmetic in nature (including but not limited to external bleaching, bleaching of non-vital discolored teeth, composite restorations, veneers, crowns on teeth not exhibiting pathology and facings on crowns on posterior teeth), including charges for personalization of dentures.
19. Charges for failure to keep a scheduled visit or charges for completion of claim forms.
20. Charges for inpatient hospital care such as room, board, ancillary and other services or facility charges for outpatient hospital/freestanding surgical facility.
21. The extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions is excluded.
22. Separate charges for general anesthesia or I.V. sedation.
23. 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.
24. Replacement of lost or stolen prosthetic devices or appliances.
25. Occlusal equilibration, except treatment due to periodontal disease.
26. The initial placement of a full denture or partial denture unless it includes the replacement of a functioning natural tooth extracted while the person was covered by this Contract.
27. The replacement of teeth beyond the normal complement of 32.
28. Athletic mouth guards; myofunctional therapy; infection control; precision or semi-precision attachments; denture duplication; separate charges for acid etch; treatment of jaw fractures; orthognathic surgery; exams required by a third party other than BCBSGA; personal supplies (e.g., oral irrigation devise and/or electronic toothbrush, toothbrush, floss holder, etc).

Limitations

If a Member transfers from the care of one Dentist to the care of another Dentist during the course of treatment, or if more than one Dentist renders services for one dental procedure, benefits will be for no more than the amount payable if only one Dentist had rendered the service.

In all cases involving services in which the Dentist and the patient select an alternative course of treatment from that which is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the condition involved, benefits will be based on the fee allowed for the most customarily provided procedure.

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 medical 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.

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 the BCBSGA's Customer Service Department. Be sure to always give your Member ID number.

Write

Customer Service Department
Blue Cross and Blue Shield of Georgia, Inc.
P.O. Box 7368
Columbus, Georgia 31908

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, of 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 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 Eligible Charges 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.

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 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 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
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.

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 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 Certificateholder 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.

Covered Services

Acceptable services dental care services and supplies that are (a) defined as Covered Services in the Member's Contract, (b) not excluded under such Contract, (c) not Experimental or Investigational and (d) provided in accordance with such Contract.

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 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) 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.

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 medical 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 medical and scientific evidence. Medical and scientific evidence means:

1. Peer-reviewed scientific studies published in or accepted for publication by medical 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 medical 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. Medical 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 Medical 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 medical 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.

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 In-Network 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 our Members for Covered Services.

Physician
Any licensed Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery, any licensed Doctor of Osteopathy (D.O.) approved by the Composite State Board of Medical Examiners, any licensed Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and any licensed Doctor of Dental Surgery (D.D.S.) legally entitled to perform oral surgery. Optometrists and Clinical Psychologists are also considered covered providers when acting within the scope of their licenses, and when rendering services covered under this Contract.

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.

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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