DENTAL BENEFIT BOOKLET WITH ORTHODONTICS

For

CITY OF MARIETTA

BUY UP PLAN

Administered By

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente.

If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling customer service at the number on the back of your Identification Card.

Effective 01/01/2016

Introduction

This Benefit Booklet gives you a description of your benefits while you are enrolled under the Dental Plan (the “Plan”) offered by your Employer. You should read this Benefit Booklet carefully to get to know the Plan’s main provisions and keep it handy for reference. A thorough understanding of your coverage will allow you to use your benefits wisely. If you have any questions about the benefits shown in this Benefit Booklet, please call your Employer’s Health Plan Administrator or the Customer Service number on the back of your Identification Card.

If you have any questions about your Plan, please be sure to call Customer Service at the number on the back of your Identification Card. Also be sure to check the Claims Administrator’s website, www.bcbsga.com for details on how to find a Provider.

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

How to Get Language Assistance

The Plan is committed to communicating with Members about the health Plan, no matter what their language is. The Claims Administrator employs a language line interpretation service for use by all their Customer Service call centers. Simply call the Customer Service phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

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Summary of Benefits	
All payments are based on Covered Expense.	
Yearly Maximum Maximum per calendar year per Member based on Covered Expense	$1,500
Calendar Year Deductible Individual Family The first three members of an enrolled family to satisfy their Deductible will satisfy the Deductible for the entire family.	 $25 $75
Orthodontic Services Lifetime Maximum Benefit per Member under age 19	$1,000
Percentage Payable All payments are based on Covered Expense.	
Type 1 - Preventive and Diagnostic Services Participating Provider (not subject to Deductible) Non-Participating Provider (not subject to Deductible)*	 100% 100%
Type 2 - Basic Services Participating Provider (calendar year Deductible applies) Non-Participating Provider (calendar year Deductible applies)*	 80% 80%
Type 3 - Major Services Participating Provider (calendar year Deductible applies) Non-Participating Provider (calendar year Deductible applies)*	 50% 50%
Type 4 – Orthodontic Participating Provider Non-Participating Provider	50% 50%

*Percentage Payable for Non-Participating Provider is based on Reasonable and Customary charges.

Note: There is not a network of dental providers that a Member must utilize in order to receive these benefits. However, if the Member uses a participating Dentist, any amount over Reasonable and Customary will **NOT** be charged to the Member.

Summary Notice

This Benefit Booklet summarizes your employer's dental benefit program. The Benefit 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 Plan and governs your coverage.

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

This Benefit Booklet is an integral part of your employer's Dental Master Plan. 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.

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 Plan 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 Plan, 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.

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

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

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

Changing Your Coverage (Adding a Dependent)
You may add new Dependents to your Plan 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.

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.

Foster Children

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

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

Medicaid and CHIP Special Enrollment/Special Enrollees

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

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

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

OBRA 1993 and Qualified Medical Child Support Orders

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

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

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

Family and Medical Leave

For groups with 50 or more employees, if a covered employee ceases active employment due to an employer-approved medical leave of absence, in accordance with the Family and Medical Leave Act of 1993 (FMLA), coverage will be continued for up to 12 weeks under the same terms and conditions which would have applied had the Employee continued in active employment. The Employee must pay his or her contribution share toward the cost of coverage if any contribution is required.

Changing Your Coverage or Removing a Dependent

When any of the following events occur, notify your employer and ask for appropriate forms to complete:

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

Employee Not Actively at Work

New Hires

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

Dental Benefits

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

Covered Expenses

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

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

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

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

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

Extension of Benefits

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

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

Dental Benefit

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

Participating Dental Providers

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

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

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

Change in Dental Benefits

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

Deductible

Before certain benefits are paid, You and Your Dependents must satisfy the Deductible as stated in the **Summary of Benefits**. This Deductible must be satisfied by each Member once a calendar year. However, if You and Your covered family Members reach the Family Deductible Limit shown in the **Summary of Benefits**, then no further Deductible requirements will be applied for the balance of the calendar year.

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

Type 1 - Preventive and Diagnostic Services

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

Prophylaxis

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

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

Routine Oral Examinations

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

Dental X-rays

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

Topical Application of Fluoride

Two treatments per calendar year for Members under age 19 only. The service must be performed by a Dentist or a licensed dental hygienist under the supervision of a Dentist.

Space Maintainers

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

Diagnostic Casts

Pulp Vitality Testing

Limited to one per calendar year.

Type 2 - Basic Services

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

Simple Extractions

Fillings
Covers both silver amalgam and tooth colored synthetic materials.

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

Palliative Emergency Treatment
Covers one visit per occurrence.

Apicoectomy
Excision of the apex portion of a tooth root.

Occlusal Guards
Limited to one per lifetime.

Impactions
Surgical removal of impacted teeth.

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

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

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

Gingivectomy and gingivoplasty

Osseous Surgery
Includes flap entry and closure.

Vestibuloplasty

Type 3 - Major Services

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

Inlays

Crowns

Dentures
Includes both full and partial dentures.

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

Denture Rebase or Reline

Repair of Fixed Bridges

Repair of Removable Dentures

Re-cement crowns and bridges

Type 4 - Orthodontic Services

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

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

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

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

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

Treatment Plan

A treatment plan for services equal to or in excess of $500 is required.

Treatment Plan is a written report completed by your dentist, on forms that will be furnished to you by your Employer. The dentist indicates on this form the services to be rendered, the fee(s) to be charged, and other information necessary to identity the services. Radiographs, or x-rays, are to be attached. The dentist also indicates that the form is a claim for pre-certification of benefits. The dentist then submits the form to the Claim Administrator at the address show on your ID card.

X-rays are required on single unit crowns, inlays, veneers and services exceeding $500. The plan reserves the right to request x-rays on other services on an as needed basis.

When the Claims Administrator has reviewed the claim and determined the benefits payable, the approved benefits are indicated on the form 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 form with completed dates of service to the Claims Administrator. The dentist indicates that the form is now a claim for payment. Please be certain to have your identification 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 Plan

- Charges incurred before you were covered by this dental Plan, except as stated under the "Covered Expenses" section.
- 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.
- Charges for which You or a Covered Dependent have no obligation to pay. This does not include the cost of services and supplies provided by Medicaid or those services provided by the Veterans Administration for a non-service-related Illness or Injury.
- Any part of the normal charge for services or supplies which a Dentist offers to waive. This includes, but is not limited to, Deductibles and Coinsurance.
- Charges for treatment that is not considered to be Medically Necessary or Reasonable and Customary. The Claims Administrator determines, with the advice of medical or dental peer groups or other experts, what services, treatments or supplies are Medically Necessary and if charges are Reasonable and Customary.
- Charges for treatment which the Claims Administrator considers to be Experimental or Investigational. The Claims Administrator determines, with the advice of medical or dental peer groups or other experts, whether or not a procedure is Experimental or Investigational.
- Any Injury for which Workers' Compensation benefits, occupational injury benefits or personal liability benefits are payable. This exclusion does not apply if You are a partner or proprietor and You are not entitled to Workers' Compensation benefits.
- Services not provided by a Dentist, except the scaling and cleaning of teeth performed by a dental hygienist under the Dentist's supervision.
- Any treatment for cosmetic purposes, including, but not limited to facings on crowns or pontics posterior to the second bicuspid, unless the treatment is Medically Necessary to restore teeth lost or damaged due to an Accidental Injury which occurred while covered by this Plan.
- Personalization of dentures or teeth.
- Charges for plaque control programs and dietary instruction.
- Replacement of prosthetic devices, dentures, bridges or crowns within 5 years of its last placement.
- Replacement of lost or stolen prosthetic devices or appliances.
- Charges to adjust a prosthetic device within the first 6 months of its placement and which were not included in the device's original price.
- Occlusal equilibration, except treatment due to periodontal disease.
- Crowns, inlays, or onlays unless the extent of the cavity or fracture prevents the use of an amalgam, silicate, acrylic, synthetic, porcelain or composite filling.
- Treatment furnished or available to you in whole or in part under the laws of the United States, or any state, or political subdivision.
- Treatment for any condition, disease, ailment, injury, or diagnostic service to the extent that benefits are provided, or would have been provided had a claim been filed, under title XVIII of the Social Security Act of 1965 (Medicare), including amendments thereto.

Coordination of Group Health and Dental Program Benefits

Any dental services eligible for coverage under your health care Plan will be payable according to the provisions of the health care Plan.

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 Plan 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 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 the 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 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 COB 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 COB 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. BCBSGA has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person as necessary to coordinate benefits. BCBSGA need not tell, or get the consent of, any person to do this. Each person claiming benefits under this program must give BCBSGA 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, BCBSGA 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. BCBSGA will not have to pay that amount again.
- Right of Reimbursement. If the amount of the payment made by BCBSGA is more that it should have paid under this COB provision, it may recover the excess from one or more of:
  - the persons it has paid or for whom it has paid,
  - insurance companies, or
  - other organizations.

Subrogation

The Plan reserves the right to be reimbursed for benefits paid under this Plan if the person for whom benefits are paid has a right to recover these benefits from a third party. This is called **subrogation**. This provision helps control the cost of the Plan by limiting certain recoveries to the actual medical expense lost. In no instance shall a Member be asked to reimburse more than the actual medical expenses paid on the Member's behalf.

Right of Subrogation
If a Member incurs medical expenses as the result of injuries suffered because of the alleged negligence or misconduct of another person, the Member may have a claim against that person for payment of medical bills. The Plan will be subrogated to the right of recovery the Member has against the other person.

This right shall be only to the extent of benefits paid by the Plan for medical expenses. The Member will be required to reimburse the Plan out of any monies the Member receives from the other person or his or her insurance company as a result of judgment, settlement or otherwise. The Member will be required to furnish the Plan information and assistance required to enforce this right of subrogation. The right of subrogation shall not apply to any recovery the Member obtains from any insurance company under which the Member is the insured person. The purpose of this provision is to help provide insurance at reasonable rates. Subrogation will be administered by the Claims Administrator.

Claims and General Information

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

How to File Claims

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

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

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

Balance Billing

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

Processing Your Claim

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

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

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

Timeliness of Filing

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

Necessary Information

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

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

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

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

Write
Inquiries should be mailed to P.O. Box 9201, Oxnard, CA 93031. When asking about a claim, give the following information:
- Member ID number;
- Patient name, Subscriber name and address;
- Date of service;
- Type of service received; and
- Provider name and address (Hospital or Physician).

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

Complaints about BCBSGA Service
As a BCBSGA Member, you have a right to express dissatisfaction and to expect unbiased resolution of issues. The following represents the process established to ensure that BCBSGA gives its fullest attention to your concerns. Please utilize it to tell BCBSGA when you are displeased with any aspect of services rendered.
1. Call the Customer Service Department. The phone number is on your ID Card. Tell us your problem and we will work to resolve it for you as quickly as possible.
2. If you are not satisfied with our answer, you may file a formal complaint, preferably, but not necessarily, in writing. This request for a further review of your concerns should be addressed to the location provided by the Customer Service Representative at the number on your ID Card.
3. If, depending on the nature of your complaint, you remain dissatisfied after receiving our response, you will be offered the right to appeal our decision. At the conclusion of this formalized re-review of your specific concerns, a final written response will be generated to you, which will hopefully bring the matter to a satisfactory conclusion for you.

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

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

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

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

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

Changes in Coverage

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

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

Acts Beyond Reasonable Control (Force Majeure)

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

Care Received Outside the United States

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

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

Licensed Controlled Affiliate

The Member hereby expressly acknowledges his/her understanding this policy constitutes a contract solely between the Member Group and BCBSGA, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting BCBSGA to use the Blue Cross and Blue Shield Service

Marks in the state of Georgia, and that BCBSGA is not contracting as the agent of the Association. The Member Group further acknowledges and agrees that it has not entered into this policy based upon representations by any person other than BCBSGA and that no person, entity, or organization other than BCBSGA shall be held accountable or liable to the Member for any of BCBSGA's obligation to the Member created under this policy. This paragraph shall not create any additional obligations whatsoever on the part of BCBSGA other than those obligations created under other provisions of this agreement.

Governmental Health Care Programs

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

Under federal law, for groups with 20 or more employees, all active employees (regardless of age) can remain on the group's health plan and receive group benefits as primary coverage. Also, spouses (regardless of age) of active employees can remain on the group's dental plan and receive group benefits as primary coverage.

When Your Coverage Terminates

A. Termination of Coverage (Group)

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

1. The Group fails to pay Premiums in accordance with the terms of this Plan.
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 Plan ceases, or if you fail to make any required contribution toward the cost of your coverage. In any case, your coverage would end at the expiration of the period covered by your last contribution.

Coverage of an enrolled child ceases automatically at the end of the month 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 Plan, or this and its immediately preceding health insurance Plan, 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 Plan; 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	18 months
Covered Employee's Entitlement to Medicare	36 months
Divorce or Legal Separation	36 months
Death of a Covered Employee	36 months
For Dependents: Loss of Dependent Child Status	36 months

Continuation coverage stops before the end of the maximum continuation period if the Member becomes entitled to Medicare benefits. If a continuing beneficiary becomes entitled to Medicare benefits, then a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. For example, if you become entitled to Medicare prior to termination of

employment or reduction in hours, COBRA continuation coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement.

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

Second qualifying event

If your family has another qualifying event (such as a legal separation, divorce, etc.) during their initial 18 months of COBRA continuation coverage (or 29 months, if the disability provision applies), your spouse and Dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused your spouse or Dependent children to lose coverage under the plan had the first qualifying event not occurred. A qualified beneficiary must give timely notice to the Plan Administrator in such a situation.

Notification Requirements

In the event of your termination, lay-off, reduction in work hours or Medicare entitlement, your employer must notify the company's benefit Plan Administrator within 30 days. You must notify the company's benefit Plan Administrator within 60 days of your divorce, legal separation or the failure of your enrolled Dependents to meet the program's definition of Dependent. Thereafter, the Plan Administrator will notify qualified beneficiaries of their rights within 14 days.

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

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

Continuation of Coverage (Federal Law – USERRA)

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

Under USERRA, if the Employee (or his or her Dependents) is covered under this Plan, 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 Plan. In order to be eligible for coverage during the period that the Employee is gone on military leave, the Employee must give reasonable notice to the Employer of his or her military leave and the Employee will be entitled to COBRA-like rights with respect to his or her dental benefits in that the Member and his or her Dependents can elect to continue coverage under this Plan for a period of 24 months from the date the military leave commences or, if sooner, the period ending on the day after the deadline for the Employee to apply for or return to work with the Employer. During military leave the Employee is required to pay the Employer for the entire cost of such coverage, including any elected Dependents' coverage. However, if the Employee's absence is less than 31 days, the Employer must continue to pay its portion of the Premiums and the Employee is only required to pay his or her share of the Premiums without the COBRA-type 2% administrative surcharge.

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

> Plan 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 Plan or to the maximum of the amount payable under this Plan during the extension period.

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

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

Definitions

Acceptable Services (also called Covered Services)

Acceptable Services are services and supplies provided in connection with those services which we determine to be:

1. Acceptable and necessary for the symptoms, diagnosis, or treatment of your dental condition.
2. Provided for the prevention, diagnosis, or direct care and treatment of the dental condition.
3. Within community standards of good dental practice.

Accidental Injury

An injury to structures within the oral cavity caused by a traumatic force exterior to the oral cavity. It does not include any injury resulting from biting into food or other substance.

Administrative Services Agreement

The agreement between the Claims Administrator and the Employer regarding the administration of certain elements of the dental benefits of the Employer's Group Dental Plan.

Benefit Booklet

This document. The Benefit Booklet provides you with a description of your benefits while you are enrolled under the Plan.

Claims Administrator

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

Covered Services

Covered Services are services and supplies provided in connection with those services which the Claims Administrator determines to be:

- Acceptable and necessary for the symptoms, diagnosis, or treatment of your dental condition.
- Provided for the prevention, diagnosis, or direct care and treatment of the dental condition.
- Within community standards of good dental practice.

Covered Expense

Covered Expense is the expense you incur for Covered Services. Expense is incurred on the date you receive the service or supply for which the charge is made. Covered Expense does not include:

- For all Participating Providers, any charge in excess of the Negotiated Rate; or
- For all Non-Participating Providers, any charge by a Dentist in excess of the Maximum Allowable Charge.

Covered Dependent

Any Dependent in a Subscriber's family who meets all the requirements of the Eligibility section of this Benefit Booklet, has enrolled in the program, and is subject to Premium requirements set forth in the Dental Master Plan.

Deductible

An amount you must pay each calendar year before the Claims Administrator 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
A Member of the Subscriber's family who meets the rules listed in the "Eligibility and Enrollment – Adding Members" section of this Benefit Booklet and who has enrolled in the Plan. Eligible Dependents are also referred to as Members.

Effective Date
The date your coverage begins under this Plan.

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

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

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

Negotiated Rate
The Negotiated Rate is the rate of payment for Services that the Claims Administrator has negotiated with Participating Providers under a Participating Agreement for Covered Services furnished to covered Members. The Member will not be balance bill for Covered Services.

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

Non-Covered Services
Services that are not benefits specifically provided under the Plan, are excluded by the Plan, 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 the Claims Administrator 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 the Claims Administrator at the time services are rendered. Participating Dentists or Providers have negotiated certain charges as the Negotiated Fee Rate they will charge Members for Covered Services.

Plan

The arrangement chosen by the Plan Sponsor to fund and provide for delivery of the Employer's dental benefits.

Premium

The amount that the Employer or Member is required to pay the Claims Administrator to continue coverage.

QMCSO – Qualified Medical Child Support Order

A QMCSO creates or recognizes the right of a child who is recognized under the order as having a right to be enrolled under the health benefit plan to receive benefits for which the Employee is entitled under the plan; and includes the name and last known address of the Employee and each such child, a reasonable description of the type of coverage to be provided by the plan, the period for which coverage must be provided and each plan to which the order applies.

Reasonable and Customary Level

A charge which is the usual charge made to persons in the same geographic area for similar services or supplies.

Important Notice – The Claims Administrator may rely upon cost data and the advice of dental peer review groups and other dental experts to determine the Reasonable and Customary Level. The determination of the Reasonable and Customary Level will be made by the Claims Administrator.

City of Marietta / Marietta Board of Lights and Water HIPAA Notice

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which went into effect April 14, 2003, requires that health plans protect the privacy of individually identifiable health information. HIPAA establishes national standards for privacy, transmission and security of protected health information, limits the disclosure of health information and enables individuals to find out how their information may be used.

It is the policy of the City/BLW as a group health plan sponsor not to use or disclose information that is protected by HIPAA (protected health information) except as necessary for treatment, payment, health plan operations, plan administration functions, or as permitted or required by law. By law, the City/BLW requires all business associates to also observe HIPAA's privacy rules. In particular, the City/BLW will not use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the City/BLW without the employee's authorization.

Under the HIPAA, employees have certain rights with respect to protected health information, including certain rights to see and copy the information, receive and accounting of certain disclosures of the information and, under certain circumstances, amend the information. Employees also have the right to file a complaint with the City/BLW or with the Secretary of the U.S. Department of Health and Human Services if the employee believes his or her rights under HIPAA have been violated.

To obtain a copy of the City of Marietta Board of Lights and Water's Privacy Notice, contact the Benefits Manager, 205 Lawrence Street, Marietta, GA. 30060.

If you have questions about the privacy of your health information or wish to file a complaint under HIPAA, please contact the Benefits Manager with the City of Marietta/Marietta Board of Lights and Water.

Summary Plan Description

Plan Information

1. **Plan Name:**
   City of Marietta/Marietta Board of Lights and Water Health Care Plan

2. **Plan Sponsor:**
   City of Marietta and Marietta Board of Lights and Water
   205 Lawrence Street
   Marietta, Georgia 30060

3. **Plan Year:**
   The Calendar Year

4. **Claims Administrator:**
   Blue Cross and Blue Shield Healthcare Open Access POS benefit plan, Inc.
   3350 Peachtree Road
   Atlanta, Georgia 30326

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