DENTAL PLAN WITH ORTHODONTICS

DOUGLAS COUNTY BOARD OF COMMISSIONERS

Administered By

BlueCross BlueShield of Georgia

NOTICE

This document which is called the **Benefit Booklet**, describes the health plan (herein called the Plan) as established by **DOUGLAS COUNTY BOC** (herein called the Employer or Plan Sponsor).

This Benefit is a part of the Employer's **Health Plan Document** which Blue Cross and Blue Shield of Georgia, Inc. **(herein called the Claims Administrator)**, an Independent Licensee of the Blue Cross and Blue Shield Association, administers under the Employer's Self-funded Plan.

Every effort has been made to accurately describe the Plan in this Benefit Booklet. However, if there should be a discrepancy between this Benefit Booklet and the Health Plan Document—or if the Plan is required to operate in a different manner to comply with federal laws and regulations – the Health Plan Document or the appropriate federal laws and regulations will control.

Important: This is not an insured benefit Plan. The benefits described in this Benefit Booklet or any rider or amendment attached hereto are self-insured by the Employer who is responsible for their payment. Blue Cross and Blue Shield of Georgia, Inc. provides claims administration services for the Plan, but Blue Cross and Blue Shield of Georgia, Inc. does not insure the benefits described.

DISCLAIMER

This publication is distributed to Douglas County employees for the purpose of providing the terms and conditions of the Group Health Plan (GHP), also known as the Employee Health Benefit Plan. As the sole basis for the County's GHP, employees must reference this Benefit booklet for the terms and conditions of their medical, dental and vision insurance coverage. Only employees who are eligible for medical coverage and who are registered members of "the Plan" have any rights to such medical, dental or vision insurance coverage. Eligible full-time employees who desire coverage should contact Douglas County's Human Resource Department for further instruction on how to enroll.

Although the terms and conditions described in this Benefit Booklet have been thoroughly edited for accuracy, content and grammar, it is understood that errors or omissions in the development and/or printing may occur and that the Board of Commissioners is not responsible for such miscommunications or any damages that may be incurred. This Benefit Booklet can be modified or updated without prior notice.

While the Human Resource Department and its employees are trained and informed as to the contents of this Benefit Booklet, the terms and conditions of this document precedes any explanation of benefits, services, instruction or direction provided orally to any employee. All County employees are responsible for knowing the contents of this Benefit Booklet and following the terms and conditions as outlined. Furthermore, employees / members are responsible for the accuracy of Protected Health Information (PHI), to include but not limited to, levels of deductibles, personal contact information and marital and dependent status.

Table of Contents

Summary of Benefits ..... **i**

Eligibility **1**

Dental Benefits **4**

Type 2 - Basic Services **7**

Type 3 - Major Services **9**

Type 4 - Orthodontic Services **10**

Pre-Determination of Benefits **11**

What's Not Covered by your Dental Plan **12**

Coordination of Benefits (COB) **14**

Subrogation **16**

Claims and General Information **17**

When Coverage Terminates **20**

Definitions **24**

Summary Plan Description **29**

Notice of Privacy Practices **31**

Summary of Benefits

Yearly Maximum

Maximum per calendar year per Participant based on
Covered Expense $1,200

Calendar Year Deductible

Individual Deductible Amount $50
Family Deductible $150
The first three Participants of an enrolled family to satisfy their Deductible will satisfy the Deductible for the entire family.

Orthodontic Services

Lifetime Maximum Benefit per Participant under age 19.....$1,000

Percentage Payable

All payments are based on Covered Expense.

Level of Benefit	Deductible Amount Applicable	Benefit Percentage Payable
Type 1 – Preventive		
Participating Provider	NO	100%
Non-Participating Provider	NO	100%
Type 2 – Basic		
Participating Provider	YES	80%
Non-Participating Provider	YES	80%
Type 3 – Major		
Participating Provider	YES	50%
Non-Participating Provider	YES	50%
Type 4 – Orthodontics		
Participating Provider	YES	50%
Non-Participating Provider	YES	50%

Summary of Benefits

DENTAL		
	In-Network Dentist	**Out-of-Network Dentist**
Calendar Year Deductible	$50 / member; maximum of $150 family ▪ Applies to basic and major Services ▪ Maximum of three deductibles per family ▪ No deductible on preventive services	
Annual Maximum	1,200 Dentistry 1,000 Orthodontics	
Coinsurance Amounts	100% Preventive Services 80% Basic Services 50% Major Services 50% Orthodontics	100% Preventive Services 80% Basic Services 50% Major Services 50% Orthodontics
Predetermination of Benefits	For charges in excess of $350	
See Summary Plan Description (SPD) **for complete details**	It is important to keep in mind that this material is a brief outline of benefits and covered service and is not a contract. Please refer to your Summary Plan Description ("the Contract") for a complete explanation of covered services, limitations and exclusions.	
In & Out of Network Dental Coinsurance Covered Procedures		
100% Preventive Service	**80% Basic Services**	**50% Major Services**
▪ Routine oral examinations	▪ Fillings	▪ Bridges
▪ Prophylaxis (two per year)	▪ Oral Surgery	▪ Dentures
▪ Topical applications of fluoride	▪ Endodontics	
▪ Space maintainers	▪ Simple extractions	
▪ Diagnostic casts	▪ Periodontic services	
▪ Pulp vitality testing (one per year)	▪ Other visits and exams	
▪ Dental X-rays	▪ Repair of removable dentures	
▪ Sealants	▪ Re-cement crowns and bridges	50% Orthodontic Services Lifetime Maximum $1,000 for dependents up to age 19
	▪ Palliative emergency treatment	
	▪ Occlusal guards (one per year)	
	▪ Inlays	
	▪ Crowns	
	▪ Denture rebase or reline	
	▪ Repair of fixed bridge	

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

Dental

Summary Notice

This Benefit Booklet summarizes your Employer's dental benefit Plan. It is the dental benefit portion of the Health Plan Document, which governs the Plan's coverage. The Health Plan Document, any riders and amendments, comprise the entire Plan between the Employer and the Claims Administrator.

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 Plan Administrator or call the Claims Administrator's Customer Service Department (800) 627-0004 (Mon – Thur) (Fri. 8am – 8pm).

This Benefit Booklet makes up the Covered Services provisions of the Health Plan Document. Its purpose is to help you understand your coverage and to provide an explanation of the benefits that the Employer offers. Further terms and conditions of the dental coverage and other benefits are contained in the Health Plan Document. A copy of the Health Plan Document is held by the Employer; however, the Benefit Booklet provides the dental benefits for easy reference.

Customer Service

If you have a customer service question, please refer to the phone number on your Identification. Card.

Eligibility

Coverage for the Employee
This Benefit Booklet describes the benefits an Employee may receive under this dental Plan. The Employee is also referred to as a Participant.

Coverage for the Employee's Dependents
If the Employee is covered by this Plan, the Employee may enroll his or her eligible Dependents. The Employee's Covered Dependents are also called Participants.

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 the Employee.

Eligible Dependents include:
- The Employee's Spouse For the purposes of this Plan, a Spouse is the Employee's legal Spouse as recognized by the state in which the Employee lives.
- The Employee's dependent children until attaining age 26, legally adopted children from the date the Employee assumes legal responsibility, children for whom the Employee assumes legal guardianship and stepchildren. Also included are the Employee's children (or children of the Employee's Spouse for whom the Employee has legal responsibility resulting from a valid court decree.
- Children who are mentally or physically disabled and totally dependent on the Employee for support, 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 have prior Creditable Coverage prior to reaching age 26. Certification of the disability is required within 31 days of attainment of age 26. A certification form is available from the Employer or from the Claims Administrator and may be required periodically.

How to Enroll
Applications for membership may be obtained from your Employer. Employees who enroll for dental coverage that did not have prior dental coverage, have a 6-month waiting period for their Participants for Type 2, 3 or 4 Services. Employees should check with their Plan Administrator to determine if this waiting period applies.

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

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

Changing Coverage (Adding a Dependent)
As the Employee's family increases, the Employee may add new Dependents by contacting the Plan Administrator. The Employee or the Plan Administrator must notify the Claims Administrator. The Plan Administrator is the person named by the Employer to manage the Plan and answer questions about Plan details.

Coverage is provided only for those Dependents the Employee has reported to the Plan Administrator and added to the coverage by completing the correct application within 31 days of a qualifying event and/or anytime during open enrollment.

Marriage and Stepchildren

The Employee may add a spouse and eligible stepchildren within 31 days of the date of marriage by submitting a change-of-coverage form. The Effective Date will be the date of marriage. Remember, there may be an additional charge.

If the Employee 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 6-month waiting period for Type 2 Services.

Newborn and Adopted Children

If the Employee has Family Coverage or Multi-Person Coverage, no additional Premium is required and coverage automatically continues. **However, the Employee must notify the Plan Administrator of the birth or adoption within 31 days to ensure accurate records and timely payment of claims.**

A newborn or an adopted child is covered automatically for 31 days from the moment of birth or date of assumption of legal responsibility up to age 26. If additional Premium is required to continue coverage beyond the 31-day period, the Employee must notify the Plan Administrator 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 the Employee 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 6-month waiting period for Type 2 Services.

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 Coverage or Removing a Dependent

When any of the following events occur, the employee must notify Douglas County's Human Resource Department within 31 days and ask for the appropriate forms to complete:

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

Employee Not Actively at Work

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. The Employee is also a person still employed by the Group but not currently active due to health status.

Dental Benefits

Your 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. The Claims Administrator 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, the Claims Administrator 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 Plan terminates, benefits will be continue for a period of 90 days for the following:

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

The Claims Administrator 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 the Claims Administrator.

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 Participant 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

This Plan 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 Participant 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 Participants 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 for Participants under 15 years of age to maintain existing space from the premature loss of deciduous teeth (primary or baby teeth) by means of a fixed or removable appliance designed to prevent adjacent and opposing teeth from moving. Adjustments are covered if required because of relative change in the condition of the mouth.

Diagnostic Casts

Pulp Vitality Testing (one per calendar year)

Sealants
For permanent teeth (limited to covered dependent children between the ages of 6 and 19 years old, once per tooth every 36 months).

Type 2 - Basic Services

After the calendar year Deductible is met, this Plan 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 year.

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

Repair of Removable Dentures

Re-cement crowns and bridges

Inlays

Crowns

Denture Rebase or Reline

Repair of Fixed Bridges

Type 3 - Major Services

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

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 you are covered under this Plan, and
- the replacement or addition of teeth is required to replace one or more additional natural teeth extracted while covered under this Plan and after the existing denture or bridge was installed; or if
- the existing denture or bridge cannot be made serviceable.

Type 4 - Orthodontic Services

This Plan 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 Participant as shown in the Summary of Benefits. This benefit only applies to Participants 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.

Pre-Determination of Benefits

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

Type 4 Services are excluded from this dollar maximum. The Claims Administrator 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 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 the Claims Administrator. Please be certain to have your Participant 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

1. Services for which the Participant 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 Plan.
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. Appliances or restorations done specifically to increase vertical dimensions or restore the occlusion.
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 the Claims Administrator's judgment, Experimental or Investigational for the diagnosis for which the Participant is being treated. An Experimental or Investigational service is not made eligible for coverage by the fact that other treatment is considered by a Participant'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 any prosthetic appliance, 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. Periodontal splinting (intracoronal and extracoronal).
13. Charges for education or training in and supplies used for dietary or nutritional counseling, personal oral hygiene or dental plaque control.
14. 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.
15. Charges for treatment by other than a Dentist, except for services rendered by a dental hygienist under the direct supervision of a Dentist.
16. 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, facings on crowns on posterior teeth and charges for personalization of dentures.
17. Charges for failure to keep a scheduled visit or charges for completion of claim forms.
18. Charges for inpatient hospital care such as room, board, ancillary and other services or facility charges for outpatient hospital/freestanding surgical facility.
19. Extractions: The extraction of immature erupting third molars and non-pathologic, asymptomatic third molar extractions is excluded.
20. Separate charges for general anesthesia or I.V. sedation.
21. 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.
22. Removal of impacted teeth.

Limitations

If a Participant 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 the Employee, the Employee's spouse, or the Employee's Dependents have duplicate coverage under 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 plan. The total benefits paid by both plans 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 plans 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**
  Medical benefits available through automobile insurance coverage will be determined before that of any other plan.
- **Non-Dependent/Dependent**
  The benefits of the plan which covers the person as an Employee (other than as a Dependent) are determined before those of the plan which covers the person as a Dependent.
- **Dependent Child/Parents Not Separated or Divorced**
  Except as stated below, when this Plan and another plan cover the same child as a Dependent of different persons, called **"parents"**:
  - The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year.
  - If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

  However, if the other plan 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 plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
- **Dependent Child/Parents Separated or Divorced.**
  If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
  - first, the plan of the parent with custody of the child;
  - then, the plan of the Spouse of the parent with the custody of the child; and
  - finally, the plan 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 health care expenses, and the company obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the 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 health care expenses of the child, the plans 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 plan that covers a person as an Employee who is neither laid off nor retired (or as that Employee's Dependent) are determined before those of a plan that covers that person as a laid-off or retired Employee (or as that Employee's Dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- **Longer/Shorter Length of Coverage**
  If none of the above rules determine the order of benefits, the benefits of the plan which covered an Employee or Participant longer are determined before those of the plan that covered that person for the shorter time.

Effect on the Benefits of This Plan

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

Reduction in this Plan's Benefits

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

- the benefits that would be payable for the Allowable Expenses under this Plan in the absence of this COB provision; and
- the benefits that would be payable for the Allowable Expenses under the other plans, 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 Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

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

Miscellaneous Rights

- **Right to Receive and Release Necessary Information**
  Certain facts are needed to apply these COB rules. The Claims Administrator 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. The Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Claims Administrator any facts it needs to pay the claim.
- **Facility of Payment**
  A payment made under another plan may include an amount which should have been paid under this Plan. If it does, the Plan 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 Plan. The Plan will not have to pay that amount again.
- **Right of Recovery**
  If the amount of the payment made by the Plan is more than 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 recoveries 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 dental expense lost. The purpose of this provision is to help the Employer continue providing high-quality dental benefits. In no instance shall the Participant be asked to reimburse more than the actual dental care expenses paid on his/her behalf.

Right of Subrogation

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

This right shall be only to the extent of benefits paid by the Plan for medical expenses. The Participant will be required to reimburse the Plan out of any monies the Participant receives from the other person or his or her insurance company as a result of judgment, settlement or otherwise. The Participant 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 Participant obtains from any insurance company under which the Participant 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, the Claims Administrator should receive the proper claim form within 90 days after the service was provided. This section of your Benefit Booklet describes when to file a benefits claim.

How to File Claims

Each person enrolled through the Employer's dental Plan receives an Identification Card. Your Dentist's office personnel will need the group and 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 Plan, 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 identification numbers shown on the form are incorrect.

Balance Billing

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

Processing Your Claim

You are responsible for submitting 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 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 Claims Administrator's 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 of the reason for the delay and will receive a list of all information needed to continue processing your claim. After you return the information, claims processing will be completed.

Necessary Information

In order to process your claim, the Claims Administrator may need information from the provider of the service. As a Participant, you agree to authorize the Dentist or other provider to release necessary information. Such information will be considered confidential. However, both the Plan and the Claims Administrator have the right to use this information to defend or explain a denied claim.

Unauthorized Use of Identification Card

If you permit your 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 Claims Administrator's Customer Service Department. Be sure to always give your identification number.

Write

Please refer to your Identification Card for the claim mailing address. When asking about a claim, give the following information:

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

Complaints about BCBSGA Service

As a Participant, you have a right to express dissatisfaction and to expect unbiased resolution of issues. The following represents the process established to ensure that your concerns are given the fullest attention.

- Call the Customer Service Department. The phone number is on your Identification Card. Tell the representative your problem and he or she will work to resolve it for you as quickly as possible.
- If you are not satisfied with the 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 Identification Card.
- If, depending on the nature of your complaint, you remain dissatisfied after receiving the response, you will be offered the right to appeal the decision. The Claims Administrator will acknowledge receipt of your appeal request (written appeal preferred), within 5 working days. 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.

Complaints about Provider Service

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

Terms of Your Coverage

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

Benefit payment for Covered Services or supplies will be made directly to Participating Providers. If services are obtained from a Non-Participating Dentist, any benefit payment will be sent to the Employee.

Neither the Claims Administrator nor the Employer will supply you with a Dentist. In addition, neither the Plan nor the Claims Administrator is responsible for any injuries or damages you may suffer due to actions of any provider or other person.
In order to process your claims, the Claims Administrator 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 an employee of the Claims Administrator, Plan Administrator, Plan Sponsor or Employer is not legally binding.

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

General Information

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

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

The Claims Administrator 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 the Claims Administrator does not assume any responsibility for compliance.

Changes in Coverage

The Plan Sponsor may change the benefits described in this Benefit Booklet. The Participant will be informed of such charges as required by law.

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. Reimbursement will be sent directly to you. Payment will be based on Covered Expense for the Participant's legal residence. Assignments of benefits to foreign providers or facilities cannot be honored.

Licensed Controlled Affiliate

The Participant hereby expressly acknowledges his/her understanding this policy constitutes a contract solely between the Employer 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 Employer 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 Participant for any of BCBSGA's obligation to the Participant created under this Plan. 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

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

Direct questions about Medicare eligibility and enrollment to your local Social Security Administration office.

When Coverage Terminates

Termination of Coverage (Individual)

Membership for You and your enrolled family members may be continued as long as you are employed by the Employer and meet eligibility requirements. It ceases if your employment ends, if you no longer meet eligibility requirements, if the 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 when the child attains the age limit shown in the **Eligibility** section. Coverage of a disabled child over age 26 ceases if the child is found to be no longer totally or permanently disabled. Coverage of the Spouse of an Employee terminates automatically as of the date of divorce or death.

Should you or any family Participants be receiving covered care in the Hospital at the time your membership terminates for reasons other than your Employer's cancellation of this Plan, or failure to pay the required Premiums, benefits for Hospital Inpatient care will be provided only to the extent available for that Hospital stay.

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.

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 Participant 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 the 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 Douglas County's Human Resource Department within 31 days.

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 also applies if any covered family member is found to be disabled.) This provision would only apply if the qualified beneficiary provides notice of disability status within 60 days of the disabling determination. In these cases, the employer can charge 150% of Premium for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the disabled at 29 months. (If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, such qualified beneficiary must notify the Plan Administrator of that fact in writing within 30 days after the Social Security Administration's determination.)

Continuation of Coverage (Federal Law – USERRA)

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

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

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

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.

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; or
- the Group terminates all of its group welfare benefit plans.

Definitions

Acceptable Services (also called Covered Services)
Acceptable Services are services and supplies provided in connection with those services which the Claims Administrator determines 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 Employer which applied for this Plan.

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

Benefit Period
One year, December 1 – November 30. Also called calendar year. It does not begin before a Participant's Effective Date. It does not continue after a Participant's coverage ends.

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 the Employee's family who meets all the requirements of the Eligibility section of this Benefit Booklet, has enrolled in the Plan, and is subject to Premium requirements set forth in the Health Plan Document.

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

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

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

reimbursement formula as we determine appropriate; and (4) we will use that data to determine allowances for services performed by Non-Participating Dentists which we have determined reasonably reflects the common range of fees charged by a majority of Dentists for a given service in a given geographic region.

Covered Services

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

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

Effective Date

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

Employee

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

Employer

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

Experimental or Investigational

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

1. Peer-reviewed scientific studies published in or accepted for publication by dental journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
2. Peer-reviewed literature, biomedical compendia, and other dental literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medikus (EMBASE), Medline, and MEDLARS data base or Health Services Technology Assessment Research (HSTAR);

3. Dental journals recognized by the United States Secretary of Health and Human Services, under Section 18961 (t) (2) of the Social Security Act;
4. The following standard reference compendia: the American Hospital Formulary Service-Drug Information, the American Dental Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;
5. Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, and any national board recognized by the National Institutes of Health for the purpose of evaluating the dental value of health services; or
6. It meets the Technology Assessment Criteria as determined by BCBSGA as outlined in the "Definitions" section of this Benefit Booklet.

Group

The Employee's Employer, which has entered into a contract with BCBSGA. The Group shall act only as an agent of Participants who are members of the Group and their eligible Dependents.

Health Plan Document

This Benefit Booklet in conjunction with the Plan, the Application, if any, any amendment or rider, your Identification Card and your Application for Enrollment constitutes the entire Plan. If there is any conflict between either this Benefit Booklet or the Plan and any amendment or rider, the amendment or rider shall control. If there is any conflict between this Benefit Booklet and the Plan, the Plan shall control.

Identification Card

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

Initial Enrollee

A person actively employed by the Employer (or one of that person's eligible Dependents) on the original Effective Date of the Health Plan Document.

MCSO-Medical Child Support Order

An MCSO is any court judgment, decree or order (including a court's approval of a domestic relations settlement agreement) that:

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

Medically Necessary

Procedures, supplies, equipment or services that are considered to be:

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

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

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

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

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

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 BCBSGA to provide services to its Participants at the time services are rendered.

Participant
The Employee and each Dependent, as defined in this SPD booklet, while such person is covered by this Plan.

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 Participants for Covered Services.

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

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

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

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

Reasonable and Customary Level
A charge which is the usual charge made to persons in the same general locality for similar services or supplies.

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

Technology Assessment Criteria

Five criteria all procedures must meet in order to be Covered Services under this Plan.

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.

Summary Plan Description

- **Plan Name:**
  Douglas County Board of Commissioners Employee Health Benefit Plan

- **Plan Sponsor:**
  Douglas County Board of Commissioners

- **Plan Number:**
  501

- **Employer I.D. Number:**
  58-6000818

- **Type of Plan:**
  The Plan is an Employee welfare benefit plan providing group medical benefits.

- **Plan Year Ends:**
  November 30

- **Type of Administration/Funding:**
  Medical benefits are furnished under a health care plan funded by the Plan Sponsor on a self-funded basis with claims being administered by Blue Cross and Blue Shield of Georgia, Inc. on behalf of **DOUGLAS COUNTY BOARD OF COMMISSIONERS**

- **Plan Administrator and Named Fiduciary:**
  Mark Teal, PE
  Douglas County Board of Commissioners
  8700 Hospital Drive
  Douglasville, Ga. 30134

- **Agent for Service of Legal Process:**
  Mark Teal, PE
  Douglas County Board of Commissioners
  8700 Hospital Drive
  Douglasville, Ga. 30134
  (770) 920-7266

- **Description of Benefits:**
  The Plan Description sets forth the benefits provided under this Dental Plan. A brief explanation of these benefits may be found in the section entitled "**Summary of Benefits**". A more detailed description of the benefits appears in the sections entitled "**Benefits**".

- **Eligibility for Participation:**
  The eligibility requirements for participation under this Dental Plan are set forth in the Plan Description in the section entitled "Eligibility".

- **Claims Procedures:**
  The Summary Plan Description contains information on reporting claims, including the time limitations on submitting a claim. Claim forms may be obtained from the Claims Administrator or the Plan Administrator. Note that the Claims Administrator is not the Plan Administrator nor the administrator for the purposes of ERISA.

- **Review of Claim Denial:**
  If your claim is denied in whole or in part, you will receive a notice of the denial. The notice will explain the reason for the denial.

  You, your beneficiary, or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request with the Claims Administrator for a review. In connection with such a request, documents pertinent to the administration of the Plan may be reviewed and issues outlining the basis of the appeal may be submitted. You may have representation throughout the review procedure.

  Your request for review must be filed within 60 days after the receipt of the written notice of denial of a claim. A decision will be rendered no later than 30 days after the receipt of the request for review. If there are special circumstances, the decision shall be rendered as soon as possible, but no later than 120 days after receipt of the request for review. The decision after the review shall be in writing and shall include specific reasons for the decision. This decision shall include specific reference to the pertinent benefit provisions of the Plan on which the decision is based. In any event, the Plan Administrator shall have the final authority regarding the disposition of disputed claims.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

Effective Date: April 14, 2004

Amended Effective: January 28, 2008

INTRODUCTION

As part of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), we are required by law to:

Make sure that protected health information is kept private; (1) Give you this notice of our legal duties and privacy practices with respect to protected health information about you; and (2) Follow the terms of the notice that is currently in effect.

This notice will tell you about the ways in which the Plan, Plan Sponsor and their respective agents may use and disclose protected health information about you without authorization. These persons and entities may share medical information with each other for treatment, payment or health care operations purposes as described in this notice. This notice also describes your rights and certain obligations the Plan and the Plan Sponsor have regarding the use and disclosure of your medical information.
The term "Protected Health Information" means any individually identifiable health information relating to the physical or mental health or condition of an individual, the provision of health care to an individual, or payment for the provision of health care to an individual. Protected Health Information does not include health information that is public or that has been identified in accordance with the standards for de-identification provided for in the HIPAA Privacy Rule.

CHANGES TO THIS NOTICE
We reserve the right to change this notice. Any changes in the notice will apply to medical information the Plan already has about you as well as any information the Plan receives in the future. The Plan will post a copy of the current notice in the facilities of the Plan Sponsor. The notice will contain on the first page, in the top right-hand corner, the effective date.

ACCOUNTING OF DISCLOSURES
You have the right to request an "accounting of disclosures." This is a list of some of the disclosures the Plan made of medical information about you that were not specifically authorized by you in advance. To request this list or accounting of disclosures, you must submit your request in writing to the Plan's Privacy Officer. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2004. Your request should indicate in what form you want the list (on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, the Plan may charge you for the costs of providing the list. The Plan will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

RESTRICTIONS ON USE AND DISCLOSURE
You have the right to request a restriction or limitation on the protected health information the Plan uses or discloses about you for purposes of treatment, payment or operations. To request restrictions, you must make your request in writing to the Plan's Privacy Officer. In your request, you must tell us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to

whom you want the limits to apply. ***We are not required to agree to your request.*** If the Plan does agree, the Plan will comply with your request.

ALTERNATIVE COMMUNICATIONS

You have the right to request to receive communications from us on a confidential basis by using alternative means for receipt of information or by receiving the information at alternative locations. For example, you can ask that the Plan only contact you at work or by mail, or at another mailing address, besides your home address. The Plan must accommodate your request, if it is reasonable. You are not required to provide us with an explanation as to the reason for your request. Contact the Plan's Privacy Officer if you require such confidential communications.

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, request a copy from the Plan's Privacy Officer in writing.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact Lisa Watson, the Plan's Privacy Officer, at (770) 920-7266. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, the Plan will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that the Plan will be unable to take back any disclosures the Plan has already made with your permission. The Plan Sponsor will keep a record of all of the persons who request and receive such information from it and will make this record available to you.

CONTACT PERSON

If you have any questions about this notice, please contact the Plan's Privacy Officer, Lisa Watson, Douglas County, County Clerk.

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

GA6447X001MI01012015