DENTAL
PLAN
WITH
ORTHODONTICS

2012

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GEORGIA BANKERS ASSOCIATION

the resource that empowers

NOTICE

This document, which is called the Summary Plan Description (SPD), describes the dental plan (herein called the Plan) as established by the **GEORGIA BANKERS ASSOCIATION INSURANCE TRUST, INC.** (herein called the Employer or Plan Sponsor).

This SPD Benefit Booklet is a part of the Employer's **Health Plan Document** which Paragon Benefits, Inc. (herein called the Claims Administrator) administers under the Employer' Self-funded Plan.

Every effort has been made to accurately describe the Plan in this SPD Benefit Booklet. However, if there should be a discrepancy between this SPD 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 SPD benefit plan. The benefits described in this SPD Benefit Booklet or any rider attached hereto are self-insured by the Employer which is responsible for their payment. Paragon Benefits, Inc. provides claim administration services to the Plan, and Blue Cross and Blue Shield of Georgia, Inc. does not insure the benefits described.

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SUMMARY OF BENEFITS

Dental Benefits

Calendar Year Maximum Benefit _____ $1,250.00
The Calendar Year Maximum is a combined maximum for all services under the Preventive, Basic and Major Dental Expense Benefits.

Orthodontic Lifetime Maximum Benefit _____ $1,000.00

Calendar Year Deductible (Under Family Coverage a Participant cannot meet more than the Individual Deductible)
Individual Deductible Amount _____ $100.00
Family Deductible Amount _____ $300.00

Type 1 – Preventive and Diagnostic Services
(Not subject to the Calendar Year Deductible)
Percentage payable _____ 100%

Type 2 – Basic Services
Percentage payable _____ 80%

Type 3 – Major Services
Percentage payable _____ 50%

Type 4 – Orthodontic Services
Deductible amount per Participant per Calendar Year _____ $100.00
Percentage payable _____ 50%

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.

Summary Notice
This SPD 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 SPD Benefit Booklet carefully. If you have any questions about your benefits as present in this SPD Benefit Booklet, please contact your Employer's Plan Administrator or call the Claims Administrator's Customer Service Department.

This SPD 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 SPD 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 Information

Eligible Employees Include:

- All Active Full-Time Employees of a Participating Employer;
- Surviving spouse until attainment of age 65; and
- Eligible surviving children until attainment of age 26.

Coverage for You

This booklet describes the benefits you may receive under your dental-care program. You are called the Subscriber or Participant.

Coverage for your Dependents

If you're covered by this program, you may enroll your eligible Dependents. Your 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 you.

Your Eligible Dependents Include:

- Your wife or husband;
- Your Dependent children until attaining 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.
- Unmarried 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 in incapacitated Dependent, the Dependent must have been covered under the Plan 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 the Plan Administrator and may be required periodically but not more frequently than annually after the two year period following the child's attainment of age 26.

If you and your spouse are both Employees of the same Employer, both of you may elect coverage, but only one may elect to have Dependent coverage.

Initial Enrollees

Initial enrollees and eligible Dependents, who were previously enrolled under group coverage which this Plan replaces, are eligible for coverage on the effective date of this coverage. Any waiting periods which were not satisfied under the previous Plan must be satisfied under this Plan. However, credit will be given for the length of time already served.

New Hires

Applications for enrollment must be submitted within 31 days from the date you are eligible to enroll as set by the Employer. Applications for membership may be obtained from your Employer. Your coverage will be effective based on the waiting period chosen by your Employer. If you or your Dependents do not enroll

when first eligible, you will be treated as a late enrollee. Please refer to the "Late Enrollees" provision below.

Late Enrollees

If you or your Dependents do not enroll when first eligible, it will be necessary to wait for the next annual enrollment date, January 1. However, you may be eligible for special enrollment as set out below.

Special Enrollment Periods

There are special enrollment periods for Employees or Dependents who:

1. Originally declined coverage because of other coverage; and
2. Who exhausted COBRA benefits, lost eligibility for prior coverage, or Employer contributions toward coverage were terminated; and
3. An individual declining coverage must certify in writing that they are covered by another dental program when they initially decline coverage under this group in order to later qualify under this special enrollment. A person declining coverage will be given notice of the consequences when they originally decline coverage.

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

Important Notes:

1. Individuals enrolled during annual enrollment are not Late Enrollees.
2. Individuals or Dependents must request coverage within 31 days of a qualifying event (i.e., marriages, exhaustion of COBRA, etc.).
3. Evidence of prior creditable coverage is required and must be furnished by you or your prior carrier.

The Participants who qualify for this waiver will be subject to all other conditions, restrictions, or limitations of this Plan.

In no event, however, will your Dependent's become effective before the date your individual coverage is effective.

Additionally, all of the above dates are subject to the section entitled "Employee Not Actively at Work".

Medicaid and CHIP Special Enrollment/Special Enrollees

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

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

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

When Your Coverage Begins – Non-contributory Insurance

If you apply when first eligible, your coverage will be effective on the first of the month following the date the Participating Employer's length-of-service requirement has been met. The effective date of coverage is subject to any length-of-service provision the Participating Employer requires.

When Your Coverage Begins – Contributory Insurance
If you apply when first eligible, your coverage will be effective on the first of the month following the date the Participating Employer's length-of-service requirement has been met. The effective date of coverage is subject to any length-of-service provision the Participating Employer requires.

Your coverage starts on the earliest of these dates:

- The first of the month following the date you are eligible, if you enroll on or before that date; or
- The first of the month following the date you enroll, if you enroll within 31 days after the date you become eligible.

Changing Your Coverage
There may be an annual re-enrollment period during which time Employees may elect to change their options.

Types of Coverage
The types of coverage available to you are stated in the **Summary of Benefits**. For the purpose of this Plan, a spouse is defined as a person of the opposite sex from that of the enrolling Subscriber.

Changing Your Coverage (Adding a Dependent)
As your family increases, you may add new Dependents by contacting the plan administrator. You or the plan administrator must provide this information 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 and added to your coverage by completing the correct application.

When Dependent Coverage Begins – Non-contributory Insurance
If you apply when first eligible, your Dependent's coverage will be effective on the first of the month following the date your Participating Employer's length-of-service requirement has been met.

When Dependent Coverage Begins – Contributory Insurance
If you apply when first eligible, your Dependent's coverage will be effective on the first of the month following the date your Participating Employer's length-of-service requirement has been met.
Your Dependents coverage will become effective on the earliest of these dates:

- The first of the month following the date you are eligible for Dependent coverage, if you do so on or have enrolled by then; or
- The first of the month following the date you enroll for Dependent coverage, if you do so within 31 days after the date you become eligible.

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 first of the month following the date of marriage. Remember, there will 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 are considered Late Enrollees. Please refer to the "Late Enrollees" provision in this section.

Newborn and Adopted Children
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. If an Employee has a type of coverage that does not require additional premium, the coverage automatically continues. However, the Employee must notify the plan administrator of the birth or adoption within 31 days.

If an Employee's coverage requires additional premium in order to add the coverage for a newborn or adopted child and this coverage is not added within 31 days, late enrollment is required. Please refer to the "Late Enrollees" provision in this section.

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 an Employee assumes legal responsibility are not covered automatically. In order for a foster child to have coverage, an Employee must provide confirmation of a valid foster parent relationship. Such confirmation must be furnished at the Employer's expense. When the application is processed, the effective date will be the first of the month following your group's Employee waiting period.

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. Pre-existing condition limitations will not apply to the child as long as the adoption (or placement for adoption) occurs while the employee is eligible for coverage.
- 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, notify your Employer and ask for appropriate forms to complete:

- Divorce;
- Death of an enrolled family member (a different type of Plan 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
If an Employee is not actively at work due to disability or injury on the date his or her coverage is to be effective, the effective date will be postponed until the date the Employee returns to active status.

Portability Provision
Any newly eligible Employee, Participant, Subscriber, enrollee or Dependent who has had similar coverage under another health benefit plan within the previous 90 days is eligible for coverage immediately. A newly eligible person is an individual who was not previously eligible for coverage under this group Plan.

Dental Benefit Program

Your group's dental program 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.
The Prudent Buyer provision of this dental plan provides for the least expensive professionally adequate treatment. The Prudent Buyer provision does not change the plan of treatment, but establishes a benefit allowance toward service upon which patient and Dentist agree. Some examples are:

- When a removable partial denture and a fixed bridge are done in the same arch, benefits will be provided for a partial denture.
- When bilateral fixed bridges are done in the same arch, benefits will be provided for a removable partial denture.

The date of incurred liability for multi-visit procedures such as root canals, dentures, partial dentures, crowns or bridges will be the date the service is completed or the date the appliance is delivered.

Calendar Year Maximum Benefit
The Calendar Year Maximum Benefit, if applicable, is shown in the **Summary of Benefits**. This amount is provided for each Participant enrolled. This maximum is based on a percentage of payment of the Usual, Customary, and Reasonable (UCR) Fees for services rendered. The Calendar Year Maximum Benefit is a combined maximum for Preventive, Basic, and Major Dental Expense Benefits.

Orthodontic Lifetime Maximum Benefit
The Orthodontic Lifetime Maximum Benefit, if applicable, is shown in the Summary of Benefits. This amount is provided for each Participant enrolled. This maximum is based on a percentage of payment of the Usual, Customary and Reasonable (UCR) Fees for services rendered. The Lifetime Orthodontic Maximum Benefit is a separate Maximum Benefit and does not apply to the Calendar Year Maximum benefit.

Deductible
You must pay the Deductible amount shown in the **Summary of Benefits**. There is a combined Deductible for Basic, Major, and Orthodontic Services.

If, during a Calendar Year, eligible family members satisfy all or a portion of the Individual Deductibles, which when added together, equal the Family Deductible limit, the Individual Deductible will not apply to any other eligible family members during the remainder of such Calendar Year.

Only one Individual Deductible shall apply to all covered Dental Services for which benefits were predetermined in connection with a Treatment Plan.

Percentage Payable
After the Deductible has been met, benefits will be paid at the Percentage Payable as shown in the **Summary of Benefits**.

Limitations for Late Enrollees

Benefits will not be provided for Major and Orthodontic services rendered to a Participant who becomes insured under the Dental Plan as a "late enrollee" until the Participant has been covered under the Dental Plan for 18 consecutive months.

Covered Dental Services

Type 1 – Preventive Services
Your program pays the amount shown in the **Summary of Benefits** of eligible charges for the following services.

Prophylaxis
Two treatments in a period of 12 consecutive months. 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.

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.

X-rays and Pathology
Except for injuries, covered charges include examination and diagnosis. Radiographs, full mouth x-rays or panoramic x-rays (not more than once in any period of 36 consecutive months). It also includes bitewing x-rays limited to twice in a period of 12 consecutive months and other dental x-rays as required in connection with the diagnosis of a specific condition requiring treatment.

Topical application of fluoride
One treatment in a period of 12 consecutive months for children up to age 18. 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. Benefits are limited to initial appliance only for children up to age 16. Adjustments are covered within 6 months of installation.

Type 2 – Basic Services
After the Deductible is paid, your program pays the amount shown in the **Summary of Benefits** of eligible charges for the following services.

Non-Routine Visits

Extractions

Impacted Teeth

Oral Surgery
Includes local anesthesia and routine post-operative care.

Drugs – Injectable Antibiotics

Alveolar or Gingival Reconstructions

Cysts and Neoplasms

Anesthesia
General, in conjunction with any covered surgical procedure.

Periodontics
Includes post-surgical visits.

Endodontics

Root Canals (Treatment of non-vital teeth)
Allowances include necessary x-rays, and cultures but exclude final restoration.

Fillings
Covers both silver amalgam and tooth colored synthetic materials.

Full and Partial Denture Repairs

Recement Crowns and Bridges

Denture Relinings and Rebasings
Allowable after 6 months of installation of appliance.
Upper and lower denture duplication (jump case) per denture is limited to once in a period of 36 consecutive months.
Denture reline (includes full and partial), office, cold cure is limited to once in a period of 12 consecutive months.
Tissue conditioning, per denture (maximum of two treatments per arch) is limited to once in a period of 12 consecutive months.

Sealants
For permanent teeth (limited to covered Dependents up to age 16. Molars only and only once in a lifetime).

Denture Adjustments
Adjustments to dentures more than six months after installation or if by other than a Dentist providing the appliance.

Type 3 – Major Services
After the Deductible is paid, your program pays the amount shown in the **Summary of Benefits** of eligible charges for the following services.

Restorative
Cast restorations and crowns are covered only when necessitated by decay or traumatic injury and the tooth cannot be restored with a routine filling material.

Inlays/Onlays

Crowns

Prosthodontics – Bridge Abutments

Pontics

Removable Bridges (unilateral)

Repairs, Crowns and Bridges

Dentures and Partial Dentures
Covered charge for dentures and partial dentures include adjustments and relines within 6 months after installation. Specialized techniques and characterizations are not covered.

Repairs, Partial Dentures
Partial Denture Repairs (metal). Covered charges based upon extent and nature of damage and type of materials involved.

Adding Teeth to Partial Denture to Replace Extracted Natural Teeth

*Replacement of any, prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge is excluded within five years of its last placement except when required due to an Accidental Injury which a Participant sustains while covered under this Plan.

Type 4 – Orthodontic Services

Orthodontic Services (See "Limitations" on page 13)
You program pays the amount shown in the **Summary of Benefits** of eligible charges for the following services. All orthodontic services are subject to the lifetime maximum shown in the **Summary of Benefits**.

Diagnosis
Includes examination, study models, radiographs and other diagnostic aids used to determine orthodontic needs.

Initial Placement of Orthodontic Appliance

Active and Retention Treatments

Minor Treatment for Tooth Guidance

Interceptive Orthodontic Treatment

Treatment of the Transitional Dentition

Treatment of the Permanent Dentition

Requirements
Charges for Orthodontic Services shall be covered only if such services are required by:

- Overbite or overjet of at least four millimeters; or
- Maxillary (upper) and mandibular (lower) arches in either protrusive or retrusive relation of at least one cusp; or
- Cross-bite; or
- An arch length discrepancy of more than four millimeters in either the upper or lower arch.

Payment Schedule
Payment for charges made in accordance with an approved Orthodontic Treatment Plan shall be made in equal monthly installments over the estimated duration of treatment. The first installment shall become payable on the date the orthodontic appliances are first installed.

Special Requirements
All orthodontic services should have a treatment plan for charges exceeding $300.

After the completion of orthodontic services as set forth in an approved treatment plan, further benefits shall be provided for orthodontic services only if at least five years have elapsed from the date the previous treatment was completed, and only if the Participant's lifetime maximum allowance has not been reached.

The lifetime maximum for orthodontic services is in addition to the maximum amount for treatment received for all other dental services.

Limitations for Major and Orthodontic Services

When Major or 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.

Benefits will not be provided for Major or Orthodontic Services rendered to a Participant who becomes insured under the Dental Plan as a late enrollee until the Participant has been covered under the Dental Plan for 18 consecutive months.

Treatment Plan

A treatment plan is a written report completed by your Dentist. The Dentist indicates in this report the services to be rendered, the fee(s) to be charged, and other information necessary to identify the services. The Dentist also indicates that the form is a claim for precertification of benefits. The Dentist then submits the form. X-rays will be requested on an as needed basis. After the precertification has been completed, the approved benefits are indicated on the form and returned to the Dentist. In this manner, the Dentist and 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. The Dentist indicates that the form is now a claim for payment. Please be certain to have your Plan and group numbers as shown on your Identification Card, so your Dentist's office can copy this information accurately.

Date of Incurred Liability

The date of incurred liability for multi-visit procedures such as root canals, dentures, partial dentures, crowns or bridges will be the date the service is completed or the date the appliance is delivered.

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. Treatments needed because of diseases contracted, or injuries sustained, as a result of war.
9. Any procedure started while you were not insured under this Plan.
10. Replacement of teeth lost before your Effective Date of coverage under this Plan.
11. The replacement of a lost, missing or stolen prosthetic device or other device or appliance.
12. Periodontal splinting (intracoronal and extracoronal)
13. Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are in Paragon Benefit'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 the Participant's Dentist to be ineffective or not as effective as the service or that the service is prescribed as the most likely to prolong life.
14. Appliances, restorations, or procedures for replacement of tooth surface lost by abrasion or attrition; or treatment of dysfunction of the Temporomandibular joint (TMJ).
15. Charges for education or training in and supplies used for dietary or nutritional counseling, personal oral hygiene or dental plaque control.
16. Implants or related services.
17. Dental services for which coverage is available to you under any other group (medical/surgical) Plan issued by BCBSGA or any other carrier.
18. Charges for treatment by other than a Dentist, except for services rendered by a dental hygienist under the direct supervision of a Dentist.
19. Charges for services or supplies that are cosmetic in nature, including charges for personalization of dentures. However, this exclusion will not apply to services required because of accidental bodily injuries if:
    - The accident occurs while the Participant is covered under this Plan;
    - The services are rendered within one year of the accident; and
    - The services are rendered while the Participant is covered under this Plan.
20. Initial placement of a partial or full removable denture or fixed bridge which replaces one or more natural teeth which were extracted prior to the date the Participant became covered under this Plan. This exclusion will not apply if the denture or bridge also replaces a natural tooth which is extracted while the Participant is covered under this Plan.
21. Charges for failure to keep a scheduled visit or charges for completion of claim forms.
22. Charges for inpatient hospital care such as room, board, ancillary and other services or facility charges for outpatient hospital/freestanding surgical facility.
23. Charges for orthodontic services and supplies except as specified in this booklet.

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 Benefits

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

Coordination of Benefits (COB)

If you, your spouse, or your Dependents have duplicate coverage under another BCBSGA group program, any other group dental expense coverage, or any local, state or governmental program, (except school accident insurance coverage and Medicaid) then benefits payable under this Plan will be coordinated with the benefits payable under the other program. Paragon Benefit's liability in coordinating will not be more than 100% UCR or the contracted amount. **The total benefits paid by both programs will not exceed 100% of the total charges.**

"Allowable Expense" means any necessary, reasonable and customary 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 person, 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 rules described above, but instead has a rule based on the gender of the parent, and if, as a result, the programs do not agree on the order of benefits, the rule in the other program will determine the order of benefits.
- **Dependent Child/Parents Separated or Divorced –** if two or more programs cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
    - First, the program of the parent with custody of the child;
    - Then, the program of the spouse of the parent with custody of the child; and
    - Finally, the program of the parent not having custody of the child.

  However, if the specific terms of a court decree state that one of the parents is responsible for the child's dental care expenses and the company obligated to pay or provide the benefits of the program of that parent has actual knowledge of those terms, the benefits of that program are determined first. This paragraph does not apply with respect to any claim determination period or program year during which any benefits are actually paid or provided before the company has that actual knowledge.
- **Joint Custody –** If the specific terms of a court decree state that the parents shall have joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the programs covering the child shall follow the order of benefit determination rules outlined above for "Dependent Child/Parents not Separated or Divorced."

- **Active/Inactive Employee –** The benefits of a program that covers a person as an Employee who is neither laid off nor retired (or as that Employee's Dependent) are determined before those of a program that covers that person as a laid-off or retired Employee (or as that Employee's Dependent). If the other program does not have this rule, and if, as a result, the programs do not agree on the order of benefits, this rule is ignored.
- **Longer/Shorter Length of Coverage –** If none of the above rules determines the order of benefits, the benefits of the program which covered an Employee or Participant 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 COB rules. Paragon Benefits, Inc. 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. Paragon Benefits, Inc. need not tell, or get the consent of any person to do this. Each person claiming benefits under this Program must give Paragon Benefits, Inc. 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, Paragon Benefits, Inc. 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. Paragon Benefits, Inc. will not have to pay that amount again.
- **Right of Recovery –** If the amount of the payment made by Paragon Benefits, Inc. 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

Right of Recovery
If you or your covered Dependents have a claim for damages or a right to reimbursement from a third party or parties for any condition, illness or injury for which benefits are paid under this program, Paragon Benefits, Inc. shall have a right of recover. Paragon Benefits, Inc. right of recovery shall be limited to the amount of any benefits paid for covered

dental expenses under this program, but shall not include non-dental items. Money received for future dental care or pain and suffering may not be recovered. Paragon Benefits, Inc. right of recovery shall include compromise settlements. You or your attorney must inform Paragon Benefits, Inc. of any legal action or settlement discussion, ten days prior to settlement or trial. Paragon Benefits, Inc. will then notify you of the amount it seeks, and the amount of your legal expenses it will pay.

Claims and General Information

How to File Claims
Under normal conditions, claims should be received within 90 days after the service is provided. This section of your booklet describes when to file a benefit claim. Each person enrolled through the group's dental program receives an Identification Card. Your Dentist's office personnel will need the group and member numbers shown on your Identification Card, as well as your name. In most cases, the Dentist's office will file the claim for you. (Please see "Treatment Plan" for related information). If the Dentist's office will not file the claim, you must submit the claim to Paragon Benefits, Inc.

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/her services and then submit an itemized statement to Paragon Benefits, Inc. when you return home.

Timeliness of Filing
To receive benefits, a properly completed claim form with any necessary reports and records must be furnished within 90 days from the date services are rendered. If the claim is not filed within 90 days, it will not affect the claim if:

- It was not possible to give proof within the required time; and
- Proof is given as soon as possible; and
- Not later than a year after it is due, unless the claimant is not legally competent.

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 this data is received, the Claims Administrator has 15 working days to complete the claims processing. The Claims Administrator shall pay interest at the rate of 18% per year if it does not meet these requirements.

Necessary Information
In order to process your claim, more information may be needed 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, Paragon Benefits, Inc. has the right to use this information to defend or explain a denied claim.

Questions About Coverage or Claims
If you have questions about your coverage, contact your Employer's Employee benefit specialist or Paragon Benefits, Inc. Be sure to always give your ID number. When asking about a claim, give the following information:

- Participant ID Number;
- Patient name; Subscribers name and address;
- Date of service; type of service received; and

- Provider name and address.

To find out if a Dentist is a BCBSGA participating provider, call them directly.

Right to Appeal

For all claims submitted by your or on your behalf, you will receive a notice (Explanation of Benefits) showing the amount charged; the amount paid by the program; and, if payment is partially or wholly denied, the reason.

If your claim is denied, or if you haven't heard anything within 90 days after you provide proof of claim, you can appeal. Your appeal rights are described in the section titled "Summary Plan Description and Statement of ERISA Rights".

Any legal action must be brought within three years after the date the services or supplies were provided.

Terms of Your Coverage

Benefits described in this booklet are only provided for eligible Participants. Any group Plan or Certificate which you received previously will be replaced by this Certificate. Paragon Benefits, Inc. does not supply you with a Dentist. In addition, Paragon Benefits, Inc. is not responsible for any injuries or damages you may suffer due to actions of any provider or other person. An oral explanation of your benefits by a Paragon Benefits, Inc. employee is not legally binding. Any correspondence will be sent to your Participating Employer.

General Information

Fraudulent statements on Subscriber application forms will invalidate any payment or claims for services and be grounds for voiding the Subscriber's coverage. All parties to this Plan (the Plan Administrator 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.

Paragon Benefits, Inc. will adhere to the Employer's instructions and allow the Employer to meet all of the Employer's responsibilities under applicable state and federal laws. It is the Employer's responsibility to adhere to all applicable state and federal laws and Paragon Benefits, Inc. does not assume any responsibility for compliance.

Changes in Coverage

Your Employer and Plan Administrator 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 exceed an established level.

Acts Beyond Reasonable Control

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

Licensed Controlled Affiliate

The Participant hereby expressly acknowledges his/her understanding this policy constitutes a contract solely between the Participant Group and the Plan Administrator.

The Participant Group further acknowledges and agrees that it has not entered into this policy based upon representations by any person other than the Plan Administrator and that no person, entity, or organization other than the Plan Administrator shall be held accountable or liable to the Participant for any of Paragon Benefits, Inc. obligation to the Participant created under this policy. This paragraph shall not create any additional obligations whatsoever on the part of the Plan Administrator other than those obligations created under other provisions of this agreement.

Calculation of Coinsurance and Other Participant Liability

When you obtain dental care services outside BCBSGA's service area, the amount you pay for Covered Services is usually calculated on the lower of:

- The actual billed charges for your Covered Services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan passes on to us.

Often this "negotiated price" will consist of a simple discount. But sometimes it is an estimated final price that factors in expected settlements or other non-claims transactions with your dental care provider or with a specific group of providers. The negotiated price may also be a discount from billed charges that reflects **average** expected savings. The estimated or average price may be adjusted in the future to correct for over- or underestimation of past prices.

In addition, laws in a small number of states require Blue Cross and/or Blue Shield Plans to use a basis for calculating your payment for Covered Services that does not reflect the entire savings realized on a particular claim. When you receive covered dental care services in those states, your required payment for these services will be calculated using their statutory methods.

When Coverage Terminates

Termination of Coverage

Termination of Coverage for Employees

Your insurance will terminate on the earliest of:

1. The date the Plan terminates; or
2. The date premium is due for you but not paid by the Participating Employer; or
3. The last day of the period for which you make any required contribution; or
4. The date you enter Active Full-Time duty, other than active duty for training purposes for 2 months or less, in the armed forces (land, water, air) of any country or international authority; or
5. The end of the month in which your employment terminates. This means you have cased Active Full-Time work in an eligible class.

If your employment terminates due to one of the following reasons, your insurance may be continued up to the maximum period of time stated below as long as the Participating Employer continues payment of premium. Such continuation will be at the Participating Employer's option, but must be according to a plan which applies to all Employees in the same way.

If your employment terminates because of disability, your insurance may be continued until the end of a period of six months following the date your employment terminated.

If your employment terminates because of documented leave of absence approved by the Participating Employer, your insurance may be continued until the end of the policy month following the second policy month in which the leave of absence commenced.

Such continuation will also end on the first to occur of the dates stated in items 1 - 5 above.

Termination of Coverage for Dependents

The insurance for your Dependents will terminate on the earliest of:

1. The date your coverage terminates;
2. The last day of the month following the date you are no longer eligible for Dependent Coverage; or
3. The last day of the month following the date the Dependent no longer meets the definition of a Dependent; or
4. The last day for which any required premium contribution is made; or
5. The last day of the month following the date you are no longer in a class eligible for Dependent Coverage; or
6. The date the Participating Employer or Plan Administrator terminates Dependent Coverage.

If, however, your insurance ends because of your death, then items 1, 4, and 5 above will not apply. Coverage for your surviving Dependents will continue until the earliest of the following dates:

- If your surviving spouse is a covered Dependent, the date such spouse remarries; or
- The date on which a Dependent ceases to meet the definition of Dependent; or
- Upon your surviving spouse's attaining the age of 65; or
- The date the Plan terminates.

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 dental insurance Plan, you may elect to continue group dental coverage for yourself and your enrolled family members for the rest of the month of termination and three additional months.

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 company'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 all the required monthly premiums in advance. This Continuation Benefit is not available if:

- Your employment is terminated for cause; or
- Your dental Plan enrollment was terminated for your failure to pay a premium or premium contribution; or
- Your dental 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 Company 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.

Continuation of Coverage (Federal Law – COBRA)
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.

This entitles each member of your family who is enrolled in the company's Employee welfare benefit plan to elect continuation, independently. Effective January 1, 1997, 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.

If your employment is terminated for any reason except your gross misconduct, or your hours of employment are reduced so that you do not qualify to participate in the company's Employee dental care Plan, you and your enrolled family members may continue your dental care benefits for as long as 18 months.

If you die, your enrolled survivors may continue their group benefits for as long as 36 months. Your enrolled spouse may continue group benefits for as long as 36 months if coverage would otherwise terminate by divorce or legal separation. Your Dependents may continue group benefits for as long as 36 months if coverage would otherwise cease because they fail to meet the definition of Dependent (for instance because of age).

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 Plan Administrator notifies you of this right, whichever is later. You must pay the total premium appropriate for the type of benefit coverage you choose to continue. 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 effective January 1, 1997, Employees who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Employee's 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 before the end of the initial 18 months eligibility period. In these cases, the Employer can charge 150% of premium for months 19 through 29.

If a continuing beneficiary becomes enrolled for other group dental care benefits, coverage may continue under this Plan only if the new group dental program contains pre-existing condition exclusions or limitations, and may continue only until these limitations cease.

These benefits are available without proof of insurability and terminate if the qualified beneficiary

- Fails to pay a required premium on time; or
- The company terminates all benefits under its Employee welfare benefit plan for all Employees.

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

COBRA is the first available option for continuing coverage.

Continuation of Coverage (Age 60 and Over)
An Employee (and eligible Dependents), insured in Georgia under a company welfare benefit plan, who has exhausted the continuation benefits listed above, is eligible for additional continuation rights if that Employee was age 60 or older and covered for continuation benefits under the regular continuation provision.

There are certain requirements which must be met:

- You must have been covered under a group plan which covers 20 or more Employees; and
- You must have been continuously enrolled for at least six months under this group Plan.

This continuation benefit is not available if:

- Your employment is terminated voluntarily for other than health reasons;
- The dental Plan enrollment was terminated because you failed to pay a premium or premium contribution;
- The dental Plan enrollment is terminated and replaced without interruption by another group Plan;
- Dental insurance is terminated for the entire class of Employees to which you belong;
- The company terminated insurance for all Employees;

- Your employment was terminated due to reasons which would cause a forfeiture of unemployment compensation (chapter 8 of Title 34 "Employment Security Law").

The following eligibility requirements apply:

- You must have been 60 years of age or older on the date coverage began under the Continuation provision;
- Your Dependents are eligible for coverage if you meet the above requirements;
- Your spouse and any covered Dependent children whose coverage would otherwise terminate because of divorce, legal separation, or your death may continue if the surviving spouse is 60 years of age or older at the time of divorce, legal separation or death.

The monthly charge (premium) for this continuation coverage will not be greater than 120% of the amount you would be charged as a normal group Employee. You must pay the first premium for this continuation of coverage under this provision on the regular due date following the expiration of the period of coverage provided under COBRA or state continuation.

Your continuation rights terminate on the earliest of the following:

- The date you fail to pay any required premium when due;
- The date the group Plan is terminated (If the group Plan is replaced, coverage will continue under the new Plan);
- The date you become insured under any other group dental plan.

Extension of Benefits in Case of Total Disability

If the group 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 the Plan Administrator (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 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: The Plan Administrator considers total disability a condition resulting from disease or injury where:

The Participant 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 Participant's Dependent is not able to engage in most of the normal activities of a person of the same age and sex.

Governmental Health Care Programs

If you are employed 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. This reduction in payment will be equal to the amount that was paid or would have been paid (if you had been enrolled) by the other program.

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

Dental Definitions

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.

Active Full-Time Employee
An Employee who works for the Employer on a regular basis in the usual course of the Employer's business. The Employee must work at least the number of hours in the Employer's normal business week. This must be at least 30 hours per week.

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.

Calendar Year
A period of time which starts on January 1 of a year and ends December 31 of that same year.

Certificate
A short written statement which defines the Plan Administrator's legal obligation to the individual Participants. It is part of this benefit booklet.

Plan
This booklet in conjunction with the Group Master Contract, any amendments or riders, your Identification Card and your enrollment application constitutes the entire Plan.

Contributory Insurance
Insurance for which the Subscriber enrolls and agrees to pay all or part of the cost.

Creditable Coverage
Coverage under another dental benefit program with no greater than a 90 day gap in coverage under any of the following: (a) Medicaid; (b) an Employer based dental insurance or dental benefit arrangement; (c) a spouse's benefits or coverage under an Employer based dental insurance or dental benefit arrangement; (d) a conversion policy; or (e) similar coverage as defined in OCGA 33-30-15.

Deductible
An amount you must pay each Calendar Year before benefit payments are made for Basic and Major services.

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

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

Effective Date
The date an individual's application is approved for coverage. For individuals who join this group after the first enrollment period, the Effective Date is the date each future Participant is approved according to normal procedures.

Employee
A person who is engaged in active employment with the group and is eligible for group coverage with the Plan Administrator under employment regulations of the group

Employer
An Employer who is a member of the Georgia Bankers Association (or certain affiliates of the Georgia Bankers Association)

Employer, Participating
An Employer, who is a member of the Georgia Bankers Association (or certain affiliates of the Georgia Bankers Association), who has adopted the Plan. Each Employer that adopts the Plan adopts it solely with respect to its own Employees. However, Plan provisions that are based on service with an Employer, such as eligibility provisions, etc., are based on service with all Employers who have adopted the Plan.

Experimental or Investigational
Services which are considered Experimental or Investigational include services which (1) have not been approved by the federal Food and Drug Administration; or (2) for which medical, 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 medical and scientific evidence. Medical 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. Medical journals recognized by the United States Secretary of Health and Human Services, under Section 18961 (t) (2) of the Social Security Act;
4. The following standard reference compendia: the American Hospital Formulary Service-Drug Information, the American 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 Paragon Benefits, Inc.

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

Initial Enrollee
A person actively employed by the Group (or one of that person's eligible Dependents) on the original effective date of the Group Master Contract between the Plan Administrator and the Group or currently enrolled through the Group.

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

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

New Hire
A person who is not employed by the group on the original effective date of the Group Master Contract.

Non-Contributory Insurance
Insurance for which a Participant does not pay a part of the cost.

Physician
Any licensed Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery, and licensed Doctor of Osteopathy (D.O.) approved by the Composite State Board of Medicine Examiners, and any licensed Doctor of Dental Surgery (D.D.S.) legally entitled to perform oral surgery.

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 dental benefit plan to receive benefits for which the Employee is entitled under the plan; and includes the name and last known address of the Employee and each such child, a reasonable description of the type of coverage to be provided by the plan, the period for which coverage must be provided and each plan to which the order applies.

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

Summary Plan Description and Statement of ERISA Rights

Plan Information

1. Plan Name:
   Group Benefits Plan for full-time Employees of the Participating Employers of the Georgia Bankers Association Insurance Trust, Inc.
2. Plan Sponsor:
   Group Insurance Plan for Employees of the Participating Employers of the Georgia Bankers Association Insurance Trust, Inc.
3. Employer I.D. Number:
   58-2241094
4. Plan Number:
   501
5. Plan Year Ends:
   December 31
6. Plan Administrator and Named Fiduciary:
   Georgia Bankers Association Insurance Trust, Inc.
   50 Hurt Plaza, Suite 1050
   Atlanta, GA 30303
   (404) 522-1501
7. Agent For Legal Process:
   Georgia Bankers Association Insurance Trust, Inc.
   50 Hurt Plaza, Suite 1050
   Atlanta, GA 30303
   (404) 522-1501
8. Type of Plan:
   The Plan provides dental coverage
9. Plan Eligibility Requirements and Summary of Benefits: This booklet describes the benefits applicable to you under the Plan. For a description of the eligibility requirements of the Plan, the amount and the type of benefits available, and the circumstances under which benefits of the Plan are not available or may terminate, please refer to this booklet.
10. Claims Procedure: For a description of how to file a claim, see the claims and general information section of this booklet.
11. Review of Claim Denial: If a claim is denied, you or your authorized representative will receive a written notice stating the basis for the denial. You will then be entitled, upon written request to a review of that claim decision. If you are not notified at all within 90 days after you submit the claim, this may be considered a claim denial and you may request a review as described above. Your request for review must be submitted within 60 days after the claim is denied. The request should be accompanied by any documents or records in support of your appeal. A decision on the request will be made in writing within 60 days after it is received, except that if special circumstances require an extension of time, you will be so notified. **In** no event will a final decision on your claim be rendered more than 120 days after the request for review. The final decision should be in writing to the claimant, with reference to the relevant Plan Provision on which the decision was based. The insurance company has the right to interpret the Plan provisions, so its decision is conclusive and binding.

More information regarding this review procedure can be obtained from Paragon Benefits, Inc.

12. Loss of Benefits: Modification of the Plan: This booklet describes the events which may cause all or part of the coverage under the Plan to terminate, and any rights you may have at such termination. One such event is termination of the Group Plan which will result in the following:
    - Termination of that part of the Plan's dental-care expense coverages for which Paragon Benefits, Inc. has liability in accordance with the group Plan's terms.

    If the group Plan terminates the Plan's benefits, to the extent they were provided under it, will also terminate unless the Employer modifies the Plan to provide those benefits from another source.

    The Plan will terminate at the end of the grace period for an unpaid premium, at any earlier date requested by the Employer, or (at the Plan Administrator's option) when the number of covered Employees falls below any minimums in the Group Plan. In the case of the Group's Plan's dental care expenses coverages, the part of the Group Plan providing those coverages will end if the benefits provided directly by the Employer end or are substantially changed.

    Georgia Bankers Association Insurance Trust, Inc. expects to continue the Plan indefinitely, but reserves the right to amend or terminate the Plan, or any part of it, at any time without the consent of persons covered under it. Amendment or termination of the Plan shall be made by the Board of Directors of the Georgia Bankers Association Insurance Trust, Inc.
13. The Plan shall not give any Employee, or any Dependent of an Employee, any right or claim except to the extent that such right or claim is specifically fixed under the terms of the Plan. The establishment of the Plan shall not be construed to give any Employee a right to be continued in the employ of the Employer or as interfering with the right of the Employer to terminate the employment of any Employee at any time.
14. ERISA Rights and Protections: As a Participant in the Group Benefits Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan Participants shall be entitled to:
    - Examine, without charge, at the Plan Administrator's office all plan documents, including insurance contracts, collective bargaining agreements and copies of all document filed by the plan with the U.S. Department of Labor, such as detailed reports and plan descriptions.
    - Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
    - Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are

discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefit Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210

15. The Plan shall be construed, and administered and governed in all respects under and by the laws of the State of Georgia and of the United States to the extent that they preempt state law or are otherwise applicable.

ERISA Appeals

If you disagree with the findings of an appealed claim payment based on medical determination, you have 60 days from the date of your notification to ask for a review before an ERISA Review Committee.

The ERISA Review Committee is composed of persons not involved in making the original decision of your claim. This committee reviews all facts on which the decision was based, any additional information you may have provided with your request for review and also may seek additional information from the hospital or provider. You will receive written notice of the committee's findings. None of these steps precludes your taking your case to civil court. Also, you have the right to be represented by an attorney in dealing with the Plan Administrator and/or Paragon Benefits, Inc. at any time.

Medical information regarding your case will be released to you or an attorney only by written authorization from your provider and/or the hospital.