DENTAL
PLAN
WITH
ORTHODONTICS

2019

GBA | INSURANCE TRUST

GEORGIA BANKERS ASSOCIATION

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TABLE OF CONTENTS

I. INTRODUCTION

This Certificate Booklet describes the benefits provided under the GBA Insurance Trust Dental Plan (the Plan), which is a component plan of the Group Benefit Plan for Employees of the Georgia Bankers Association Insurance Trust, Inc. These benefits are subject to the terms and conditions that are described in this booklet. This booklet is written in easy-to-read language to help you and your Dependents understand your dental benefits. The Plan's "Summary of Dental Benefits" summarizes your benefits and out-of-pocket costs. Together, these documents make up the Plan document and govern your coverage.

A thorough understanding of your coverage will enable you to use your benefits wisely. Please read this Certificate Booklet carefully. If you have any questions about your benefits as presented in this Certificate Booklet, please contact the Member Services Department.

Spanish (Español): Para obtener asistencia en Español, llame al 800-277-9218 opt#3.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-277-9218 opt#3.
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 800-277-9218 opt#3.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-277-9218 opt#3.
English Translation: If you need assistance, call the Member Services number: 800-277-9218 opt#3

Member Services: You may call Member Services for any question concerning your Plan benefits:

Paragon Benefits, Inc.
P.O. Box 12288
Columbus, GA 31917
1-706-321-0209 Phone
1-706-256-4089 Fax
www.paragonbenefits.com

In this booklet, Paragon Benefits is referred to as the "Claims Administrator."

Plan Sponsor: The Georgia Bankers Association Insurance Trust, Inc. is the employee organization that has established and maintains the Plan for the benefit of eligible employees and dependents.

Georgia Bankers Association Insurance Trust, Inc.
50 Hurt Plaza, Suite 1050
Atlanta, Georgia 30303
Attn: Lee Monroe, lmonroe@gabankers.com, 404-420-2013

GBA Insurance Trust is also the Plan Administrator, COBRA Administrator, Named Fiduciary and Agent for Service of Legal Process

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

II. Eligibility

Eligible Employees Include:

- All Active Full-Time Employees of a Participating Employer;

If a Covered Employee dies while covered under the Plan, his or her survivors who are then covered under the Plan will be eligible to continue coverage as follows:

- Surviving spouse until attainment of age 65 or until remarried.
- Eligible surviving children until attainment of age 26.

Types of Coverage

The types of coverage available to you are stated in the **Summary of Benefits**.

Coverage for Employees

This booklet describes the benefits you may receive under your Plan. You are called the Subscriber or Participant.

Coverage for your Dependents

If you're covered by this Plan, you may enroll your eligible Dependents. Your covered Dependents are also called Participants.

Your Eligible Dependents Include:

- Your Spouse. A Spouse means the person with whom you have established a valid marriage under the laws of the State or other jurisdiction in which you were married. The term Spouse includes same sex spouses but does not include a spouse who is married under a common law marriage.
- Your Dependent children until attaining age 26. Dependent children may include your natural children, 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 an 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 enroll a child or spouse that does not meet these criteria, that dependent will not have any coverage for the period that the eligibility criteria are not met. You will be required to repay any benefits paid on behalf of an ineligible Dependent.

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.

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 apply when first eligible, your coverage

and your Dependent's coverage will be effective on the first of the month following the date your Participating Employer's waiting period has been met. Coverage starts on the earliest of these dates:

- The first of the month following the date you are eligible; or earlier if you enrolled before the required date; 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.

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.

Changing Your Coverage

There is an annual re-enrollment period during which time Employees may elect to change their options. You may elect a different type of coverage, add or remove eligible dependents, or drop coverage. These changes will take effect on January 1 following the re-enrollment period.

Changing Your Coverage (Adding a Dependent)

As your family increases, you may add new Dependents by contacting the Plan Administrator. You must provide this information in writing.

Coverage is provided only for those Dependents you have reported and added to your coverage by completing the correct application. There will be a premium charge for dependents that will start on the effective date of coverage.

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 premium 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 premiums are 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 Employee's expense. The Employee may add a foster child within 31 days of official placement with Employee. When the application is processed, the effective date will be the first of the month following your group's Employee waiting period.

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.

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, 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.

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.

Dental Benefit Program

The 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.

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**.

Generally, a covered person must meet the Individual Deductible before any expenses are paid by the Plan. However, if, during a Calendar Year, covered 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 covered family members during the remainder of such Calendar Year.

Only one Deductible shall apply to Basic and Major Services. Orthodontic has a separate Deductible.

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

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 per Participant 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.

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 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
One treatment in a Calendar Year 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 per calendar year.
Tissue conditioning, per denture (maximum of two treatments per arch) is limited to once per calendar year.

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.

Type 4 – Orthodontic Services

Orthodontic Services (See "Limitations for Major and Orthodontic Services")
Your 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

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.
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. Periodontal splinting (intracoronal and extracoronal)
10. Appliances, restorations, or procedures for replacement of tooth surface lost by abrasion or attrition; or treatment of dysfunction of the Temporomandibular joint (TMJ).
11. Charges for education or training in and supplies used for dietary or nutritional counseling, personal oral hygiene or dental plaque control.
12. Dental implants, abutment, or related services.
13. Dental services for which coverage is available to you under any other group (medical/surgical) Plan.
14. Charges for treatment by other than a Dentist, except for services rendered by a dental hygienist under the direct supervision of a Dentist.
15. 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 services are rendered within one year of the accident unless longer period is medically necessary.
16. 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.
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. 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 including adult child(ren) have duplicate coverage under another Anthem group program, any other group dental expense coverage, or any local, state or governmental program, (except school accident insurance coverage and Medicaid) then benefits payable under this Plan will be coordinated with the benefits payable under the other program. The Plan'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. The Plan 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 Plan Administrator need not tell, or get the consent of any person to do this. Each person claiming benefits under this Program must give the Plan Administrator 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, the Plan Administrator 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. The Plan Administrator will not have to pay that amount again.
- **Right of Recovery –** If the amount of the payment made by the Plan Administrator 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, the Plan shall have a right of recovery. Its 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. The Plan's right of recovery shall include compromise settlements. You or your attorney must inform the Plan Administrator of any legal action or settlement discussion, ten days prior to settlement or trial. the Plan Administrator will then notify you of the amount it seeks, and the amount of your legal expenses it will pay.

Claims and Appeal Information

Benefits under this Plan shall be paid only if claims are properly submitted and the Plan Administrator decides that a Member is entitled to them.

How to File Claims
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 the Claims Administrator.

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 the Claims Administrator 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.

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, the Plan Administrator 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 the Claims Administrator. 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 an Anthem participating provider, call them directly.

Claims and Appeal Procedures

1. In General. Following is a description of how the Plan processes claims for benefits and reviews the appeal of any claim that is denied. The terms used in this section are defined below.

A "Claim" is defined as any request for payment of a Plan benefit, made by a claimant or by an authorized representative of a claimant, which complies with the Plan's reasonable procedure for filing claims and making benefit claims determinations.

If a Claim is denied, in whole or in part, the denial is known as the "Adverse Benefit Determination."

A claimant has the right to request a review of the Adverse Benefit Determination. This request is an "Appeal."

Both the Claims and the Appeal procedures are intended to provide a full and fair review. This means, among other things, that Claims and Appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

2. Initial Decisions on a Claim.

Upon receipt of the Claim, the Plan Administrator must decide whether to approve or deny the Claim. If the Plan Administrator denies the claim, in whole or in part, the denial is called an "adverse benefit determination."

The Plan Administrator shall notify the claimant of the Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

The Plan Administrator must notify the claimant by written or electronic notification of any adverse benefit determination. The notice will state in a culturally and linguistically appropriate manner calculated to be understood by the claimant:

(i) The specific reason or reasons for the adverse determination.
(ii) Reference to the specific plan provisions on which the determination is based.
(iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
(iv) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the ERISA following an adverse benefit determination on review.

(v) If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request.

(vi) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

3. Appealing a Claim If the claimant receives an adverse benefit determination, the claimant has the right to file a written request for an appeal of the decision. The claimant may submit written comments, documents, records, or other information relating to the Claim.
The Plan will:

i. Provide claimants at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;
ii. Provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
iii. Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.
iv. Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In addition to complying with the requirements above, the Plan will -

a. Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
b. Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
c. Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
d. Provide that the health care professional engaged for purposes of a consultation under paragraph (b) of this section shall be an individual who is neither an individual who was

consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Plan Administrator shall notify the claimant of the plan's benefit determination on review within a reasonable period of time. The notification shall be provided not later than 60 days after receipt by the plan of the claimant's request for review of an adverse benefit determination.

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. The Plan does not supply you with a Dentist. In addition, the Plan, the Plan Administrator and the Claims Administrator are 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 the Claims Administrator or its employees is not legally binding.

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.

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.

Calculation of Coinsurance and Other Participant Liability
When you obtain dental care services outside of the dental plan in network, the amount you pay for Covered Services is based on:

- The actual billed charges for your Covered Services, or
- The negotiated price that Anthem 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 Anthem 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.

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 ceased 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 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.

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 Anthem.

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.

Plan Information 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:
   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

   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 Plan by your Employer or by the Plan Sponsor. In that case, your coverage will end as of the date of termination. Eligible expenses incurred prior to the date of termination will be paid under the terms of the Plan.

   If you or your Employer fails to pay the applicable premium on time, benefits will terminate as of the last day of the month for which the full premium was paid.

   The Plan Sponsor may terminate the Plan as to all or some Employers or it may amend the Plan to terminate all or some of the benefits provided under the Plan. Although the Plan Sponsor expects to continue the Plan indefinitely, it 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. Any assets

remaining following termination of the Plan shall be disposed of in accordance with the Articles of Incorporation and By Laws of the Georgia Bankers Association Insurance Trust, Inc.

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.

ERISA Rights and Protections: As a Participant in the 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

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.