GEORGIA MUNICIPAL ASSOCIATION

GEORGIA MUNICIPAL EMPLOYEES BENEFIT SYSTEM

DENTAL PLAN
BOOKLET

NOTICE

This booklet summarizes the Dental Plan for Active Employees (the "Plan") established by **Georgia Municipal Employees Benefit System (GMEBS)** (the "Sponsor"), and administered in part by Georgia Municipal Association (the "Program Administrator") and in part by Anthem Blue Cross and Blue Shield **(the "Claims Administrator" or Anthem).** Anthem administers the benefits under the Plan. Neither the Sponsor nor the Program Administrator administers claims for dental benefits.

A thorough understanding of your coverage will enable you to use your benefits wisely. Please read this booklet carefully. If you have any questions about how much coverage costs, please contact your employer. If you have any questions about the eligibility and enrollment provisions in this booklet, please contact the Program Administrator at: GMEBS Health Plan, P.O. Box 105377, Atlanta GA 30348. If you have any questions about the benefits presented in this booklet, please contact Anthem's Customer Service Department at the number listed below. Every effort has been made to accurately describe the terms and conditions of the Plan in this Booklet. However, the full terms and conditions of the Plan are set forth in Plan Documents. In addition, if the Plan is required to operate in a different manner to comply with federal or state laws and regulations, the appropriate laws and regulations will control.

Important: This is not an insured benefit Plan. The benefits described in this Booklet (or any rider or amendment attached hereto) are self-insured. Anthem provides claims administration services to the Plan, but Anthem does not insure the benefits described. This booklet is not a contract. The benefits and other terms of coverage described in this booklet and set forth in the Plan Documents may be changed at any time.

Important Contact information for the Dental Claims Administrator

Anthem Blue Cross and Blue Shield
P.O. Box 1115
Minneapolis, MN 55440-1115

Customer Service
1-844-729-1567

Claims Address
P.O. Box 1115
Minneapolis, MN 55440-1115

www.anthem.com

NOTE: The provisions of this booklet are subject to change. The current Plan booklet is available at www.gacities.com/LHForms. Under Benefit Documents, choose the name of your Employer.

Benefit Highlights

Anthem **Georgia Municipal Employees Benefit System (GMEBS)**

Effective Date: 01/01/25

Summary of Benefits

Eligibility	Eligible Employees and Dependents (Spouse, Children) as defined in this Booklet		
Deductibles Waived for Diagnostic and Preventive (D&P) and Orthodontic Services?	$50 per person / $150 per family each calendar year Yes		
Maximum Paid by Plan Do Diagnostic and Preventive Services (D&P) and Orthodontic Benefits count toward this maximum?	$1,500 per person per calendar year No		
Waiting Period(s)	Basic Benefits 0 Months	Major Benefits 0 Months	Orthodontics 0 Months
Benefits and Covered Services*	**Participating dentists Plan Pays****	**Non-Participating dentists Plan Pays****	
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays, fluoride, space maintainers and sealants	100 %	100 %	
Basic Services Fillings, denture repairs Endodontics (root canals) Periodontics (gum treatment) Oral surgery (incisions, excisions, surgical removal of tooth)	80 %	80 %	
Major Services Crowns, inlays, onlays and cast restorations, implants, bridges and dentures	50 %	50 %	
Orthodontia Employee, Spouse, Dependent Children	50 %	50 %	
Orthodontic Maximum Benefits Lifetime	$ 1,000 Lifetime	$ 1,000 Lifetime	

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan.

** Percentage of Covered Expenses only, up to applicable Plan Maximum. Non-Anthem Dentist may balance bill you for amounts that exceed Covered Expenses.

The information contained in this Summary of Benefits does not represent a guarantee of the benefits, nor does it change or modify the governing documents underlying the Plan (the "Plan Documents.") In the event of a conflict between the information provided and the terms of the Plan Documents, eligibility for benefits and payment of benefits, if any, will be determined in accordance with and subject to the Plan Documents.

Contents

Dental Benefits

1. Eligibility and Enrollment

1.A Eligibility Information

The term "Employee" is used throughout this booklet. "Employee" can mean either a current employee or a former employee (a Retiree) who is eligible to enroll in this Plan option as a result of employment (past or present) with the Participating Employer. Some booklet provisions will clarify whether they relate to current Employees or to Retirees.

Eligibility as a Current Employee

This booklet describes the benefits an Employee who meets the definition of a Regular Employee may receive under this Plan option. An enrolled current Employee is also called a Participant. A Participating Employer's current Employee is eligible for coverage as a Regular Employee if he or she resides in the United States and is employed in a salaried or hourly rated position that requires 30 Hours of Service per week or more and is expected to last at least 48 weeks. An Hour of Service is an hour for which an employee is paid, or is entitled to payment, for the performance of duties for the employer, and each hour for which an employee is paid, or entitled to payment, due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

Participating Employers that are cities may also offer coverage to elected or appointed members of the Participating Employer's governing authority, chief and associate legal officers, and municipal judges who do not otherwise meet the definition of a Regular Employee if the city elects on its Declaration Page to offer coverage to elected or appointed members of the governing authority.

Participating Employers that are "Applicable Large Employers" within the meaning of the Patient Protection and Affordable Care Act may or may not offer coverage to workers who are not otherwise eligible for coverage, but whom the Participating Employer has identified as a "Full-Time Employee" as defined by the Patient Protection and Affordable Care Act. The Applicable Large Employer is solely responsible for determining whether to offer coverage to such individuals.

The Participating Employer may change eligibility class elections at any time or end coverage at any time. All of these Employees are referred to as Current Employees in this booklet.

Eligibility as a Retiree

If a Participating Employer has elected to offer Retiree Coverage under this Plan by filing an approved declaration electing to provide Retiree Coverage under the GMEBS Dental Plan for Active Employees ("Retiree Coverage Declaration Page) with the Program Administrator, this booklet describes the benefits a Retiree may receive. Eligibility requirements for coverage as a Retiree are set forth on the Participating Employer's Retiree Coverage Declaration Page. Information about how much Retiree coverage costs is solely maintained by the Participating Employer. A former employee may only be eligible for coverage as a Retiree if he or she was enrolled in the Plan immediately before termination of employment and retires after meeting the additional retirement requirements set forth on the Participating Employer's Retiree Coverage Declaration Page.

Dental Benefits

Eligibility as a Dependent

Covered Dependents are also called Participants. Coverage is available to dependents of Regular Employees and current members of the Participating Employer's governing authority (if elected by the Participating Employer) only if and to the extent that the Participating Employer elects on its Declaration Page to offer dependent coverage. Most Participating Employers offer coverage to all dependents (i.e., spouse and children, as described below), but some Participating Employers either do not offer any dependent coverage, or they offer dependent coverage only to certain classes of dependents (e.g., children, but not spouses). Coverage is available to dependents of Retirees only if and to the extent that the Participating Employer elects on its Retiree Coverage Declaration Page to offer them coverage. Please check with your employer to see which classes of dependents are eligible, if any.

Eligible Dependents include the following classes, if they are included as Eligible Dependents under the Participating Employer's Declaration Page or Retiree Declaration Page:

The Employee's Spouse - "Spouse" shall mean, effective before June 26, 2015, a person of the opposite sex from that of the Employee* who is joined with the Employee in a marriage recognized under Georgia law." Effective on and after June 26, 2015, "Spouse" shall mean a person who is lawfully joined with the Employee in a marriage which is recognized under the laws of any state or foreign jurisdiction, whether opposite- sex or same-sex and regardless of whether or not the spouse resides in the state or foreign jurisdiction in which such marriage occurred.

Dependent Children Until Age 26 - This includes the Employee's children until they attain age 26. For purposes of this provision, the term "children" includes biological children, stepchildren, adopted children, and foster children (See definitions of "adopted children" and "foster children" below). Children under age 26 for whom the Employee has legal responsibility to provide health insurance coverage resulting from a National Medical Support Notice or other valid court decree will also be considered children of the Employee (See " National Medical Support Notices" below).

Disabled Children After Reaching Age 26 - The Employee's unmarried children who are mentally or physically disabled prior to the age of 26, so incapacitated as to be incapable of self-sustaining employment, and chiefly dependent on the Employee for support, will be considered eligible regardless of age. However, to be eligible for coverage as a disabled dependent after reaching age 26, the dependent must have been covered under the Plan immediately prior to reaching age 26. Certification of disability is required to be provided to the Program Administrator within 31 days after attainment of age 26. A certification form is available from the Participating Employer or on www.gmanet.com/lhforms.

The Employee may be required to provide proof of the child's continued eligibility on a periodic basis in order to maintain coverage for the child.

Documentation Verifying Dependent Status

To verify eligibility for all dependents, the Program Administrator requires documentation to verify the relationship at the time of the dependents' enrollment, including but not limited to birth certificates, adoption records, and marriage certificates. Additionally, coverage under the Plan may be denied or discontinued for Employees' family members if required documentation is not provided when requested by the Program Administrator or the Claims Administrator. The Program Administrator will

require documentation of common law marriage in a state that recognizes such marriages to be in the form of a court ruling or state-issued declaration recognizing the marriage.

If an Employee and spouse are both enrolled as Employees under the Plan, either the Employee or spouse, but not both, can apply for family coverage. If the spouse with family coverage stops being enrolled as an Employee, the other spouse may become enrolled for family coverage by applying within 31 days.

Definitions

- Adopted Children: Adopted children are legally adopted children from the date the Employee assumes legal responsibility (including children placed with the Employee 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.

- Foster Children: Foster children are children who are placed with the Employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. Foster children for whom an Employee assumes legal responsibility are not covered automatically. In order for a foster child to be enrolled, the Employee must provide confirmation of a valid foster parent relationship to the Program Administrator. Such confirmation must be furnished at the Employee's expense and the child must be enrolled within 31 days after establishment of the valid foster parent relationship. If the above requirements are met, the effective date of coverage will be the first of the month following or coinciding with application for coverage of the foster child. If enrollment is not completed within the 31-day period, the foster child will be treated as a Late Enrollee (if the parent is a Current Employee), or will not be able to enroll in the Plan in the future (if the parent is a Retiree).

Coverage for Children Pursuant to National Medical Support Notice or Valid Court Order

Federal law provides specific rules for the coverage of children that are the subject of a National Medical Support Notice (NMSN).

Pursuant to these rules, a child for whom an Employee has received a NMSN, which has been determined by the Program Administrator to be qualified will be considered a Dependent Child of the Employee (see "Coverage for the Employee's Dependents" above for definition of Dependent Children).

Upon receipt of a NMSN mandating dental coverage, the Program 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 qualified and if the child is eligible to be enrolled. The Participating Employer will subsequently notify the Employee and the child(ren) of the determination.

A NMSN cannot require the Plan to provide any type or form of benefit that it is not already offering. However, coverage will be provided to the extent necessary to comply with the Georgia Child Support Recovery Act.

If an Employee is otherwise legally responsible to provide health insurance coverage for a child pursuant to a valid court decree, the child will be considered an

eligible dependent and the Employee may enroll the child within 60 days after establishment of legal responsibility pursuant to the court decree. In order to complete enrollment, the Employee must provide a copy of the court order to the Program Administrator at the Employee's expense. If enrollment is not completed within 60 days, the child will be considered a Late Enrollee. (See **"Late Enrollees (for Current Employees only)"** below).

Eligibility Waiting Period

To become eligible for benefits under this Plan, an Employee must first satisfy the eligibility waiting period set forth in the Participating Employer's Declaration Page. An Employee must also enroll himself and any eligible dependents in a timely manner in accordance with the enrollment rules of the Plan. Enrollment and coverage under the Plan is contingent upon payment of any required contributions toward the cost of coverage. (See **"Enrollment Information"** below).

1.B Enrollment Information

New Group Enrollees (When Participating Employer First Starts Participation in the Plan)

Current Employees: Employees and their eligible dependents who were enrolled under the Participating Employer's former group dental plan immediately before the former plan was replaced with this Plan will generally be eligible to enroll for coverage on the date the Participating Employer's group coverage under this Plan becomes effective. Initial Enrollees do not have to satisfy the eligibility waiting period. Those who are eligible to enroll as Initial Enrollees and who are Current Employees, but who do not enroll within 31 days after group coverage under this Plan becomes effective will be treated as Late Enrollees unless they qualify for special enrollment (See **"Late Enrollees"** and **"Special Enrollment"** below).

Retirees: Retirees and their eligible dependents who were enrolled under the Participating Employer's former group plan immediately before the former plan was replaced with this Plan will generally be eligible to enroll for coverage on the date the Participating Employer's group coverage under this Plan becomes effective and the Participating Employer's Retiree Declaration Page is approved. These Retirees and dependents must enroll within 31 days after group coverage under this Plan becomes effective. If a Retiree does not enroll a dependent by the deadline, he or she may not add the dependent at a later date except in accordance with the Special Enrollment Rules for Retirees below.

New Hires

Newly hired Employees must submit an Application for Enrollment no later than **31 days** after the Employee has satisfied the Participating Employer's eligibility waiting period. Applications for enrollment may be obtained from the Employer. If the Employee does not enroll him or herself and any eligible dependents within this time period, they will be treated as Late Enrollees, unless they qualify for special enrollment (See **"Late Enrollees (for Current Employees Only)"** and "**Special Enrollment for Current Employees"** below).

New Retirees

Retirees must submit an Application for Enrollment as a Retiree no later than 60 days following termination of employment with the Participating Employer. Applications for enrollment may be obtained from the Participating Employer. If the Retiree does not enroll him or herself at this time, he or she will not be able to participate in the Plan at a

later date. If the Retiree enrolls by the deadline, but does not enroll eligible Dependents, the eligible Dependents may only enroll at a later date if permitted under the Special Enrollment for Retirees section below. (See "**Special Enrollment for Retirees**" below).

When Coverage Begins

Except as stated below, coverage for a new hire begins on the first day of the month immediately following satisfaction of the eligibility waiting period stated in the Participating Employer's Declaration Page. If an Employee is not actively at work on the date coverage would otherwise become effective, the effective date of coverage for the Employee and any enrolling eligible dependents will be postponed until the Employee returns to active status. This is the case no matter when the Employee enrolls. If an Employee is not actively at work due to health status or because the Employee is on leave pursuant to the Family and Medical Leave Act (FMLA), this rule will not apply. For an eligible Retiree who has properly enrolled, coverage starts immediately after the date coverage as a current employee ends.

Late Enrollees (for Current Employees Only)

Initial Enrollees, newly hired Employees, and their eligible dependents who are eligible for coverage based on the Employee's current employment, but who do not enroll within 31 days after they first become eligible to enroll are considered Late Enrollees. Late Enrollees must wait until the next open enrollment period to apply for enrollment in the Plan (See **"Open Enrollment for Current Employees"** below). However, Late Enrollees may be able to enroll before the next open enrollment period if they qualify for special enrollment (See **"Special Enrollment for Current Employees"** below).

Open Enrollment for Current Employees

The Plan permits late enrollment for Current Employees only one time each year, during "Open Enrollment." Late Enrollees will have a window period of a few weeks (usually during the fall), to enroll in the Plan for an effective date of January 1st of the next year. Please check with your Employer to see when Open Enrollment begins and ends.

If a Late Enrollee does not enroll during the open enrollment period, he or she may not apply for enrollment until the next open enrollment period, unless the Late Enrollee qualifies and applies for special enrollment before then.

During Open Enrollment, covered Current Employees may elect to change their Plan option to any option made available by the Participating Employer. Covered Current Employees may also elect to change from single to family coverage (and vice versa) during the open enrollment period, depending on the Plan options provided by their Employer.

Open Enrollment for Retirees.

During Open Enrollment, enrolled Retirees may change coverage to any dental Plan option offered by the Participating Employer to Retirees. Available options are state on the Participating Employer's current Retiree Declaration Page. Retirees may not add dependents during the Open Enrollment unless a Special Enrollment event permits the addition.

Special Enrollment for Current Employees

Employees and their eligible dependents may be able to enroll without having to wait for the next open enrollment period, if they are otherwise eligible for coverage and if they experience certain "special enrollment" events. Coverage will be provided only for those

who have been reported to the Program Administrator and on whose behalf a timely and complete special enrollment application is submitted to the Program Administrator. If an Employee already has "full" family coverage that includes spouse and children and enrolls an additional eligible dependent during a special enrollment period, then no additional premium will be required. However, Employees with single coverage must pay the additional premium for dependent and/or full family coverage in order to complete special enrollment for eligible dependents. Below is a description of the special enrollment events and the rules applicable to each.

There are different special enrollment rules for Retirees. See **"Special Enrollment for Retirees"** below.

Special Enrollment Events (for Current Employees Only)

A. Loss of Other Health Coverage (for Current Employees Only)

If an Employee initially declines coverage under this Plan for himself (or for an eligible dependent) because of other health insurance coverage, the Employee may be able to enroll himself or the eligible dependent upon loss of the other coverage. In order for a dependent to be eligible for enrollment, the Participating Employer must offer coverage to the class of dependents to which the dependent belongs (See **"Eligibility as a Dependent"** above). A completed application for special enrollment must be submitted within 31 days after the other coverage ends. To qualify for special enrollment due to loss of other coverage, the Employee or eligible dependent must lose the other coverage for one of the following reasons:

- He or she became ineligible for the other coverage; or
- Employer contributions toward the cost of the other coverage have been terminated; or
- He or she was receiving COBRA coverage under the other plan and the COBRA coverage period has been exhausted.

Special Enrollment Period - The special enrollment period ends no later than **31 days** after any of the above-described events. If the Employee or eligible dependent is not enrolled within this period, then the right to special enrollment as a result of the loss of other coverage will be forfeited. In such case, the Employee or eligible dependent will be treated as a Late Enrollee and will have to wait until the next open enrollment period to enroll. (See **"Open Enrollment for Current Employees"** above).

Special enrollment **is not** available if the other coverage is lost because of failure to pay for it, or for cause, such as making a fraudulent claim. Certain forms of insurance coverage may not qualify as other health coverage for purposes of special enrollment. The Employee or eligible dependent is responsible for providing the Program Administrator with proper evidence of the other group health plan or health insurance coverage.

Effective Date of Coverage - If a special enrollment application is submitted in a timely manner, then coverage for a special enrollee who has lost other coverage will generally become effective on the first day of the month coinciding with or following submission of the completed enrollment application and payment of any required contribution. Coverage will be subject to the active work requirements of the Plan (See **"Employees Not Actively at Work"** above).

B. New Dependents (Current Employees Only)

The special enrollment rules also allow Employees to enroll themselves and certain

"new" eligible dependents without having to wait until the next open enrollment period under certain circumstances. Coverage is available under the following circumstances, if the Participating Employer offers coverage to the class of dependents to which the "new" dependent belongs (See **"Eligibility as a Dependent"** above):

- If an Employee marries, the Employee may enroll his new spouse, himself, and any eligible dependents if not previously covered.
- If an Employee acquires a new eligible dependent child by birth, adoption, placement for adoption, or marriage (stepchild), the Employee may enroll his new eligible dependent child. If the Employee initially declined enrollment for himself, his spouse, or any other eligible dependents, the Employee and any eligible dependents may also enroll at this time.

Special Enrollment Period - To qualify for special enrollment, the Employee and any eligible dependents must enroll within **31 days** of the event (marriage, birth, adoption, or placement for adoption) that triggers the right to special enrollment. If the Employee or eligible dependent is not enrolled within this period, then the right to special enrollment will be forfeited. The Employee or eligible dependent will be treated as a Late Enrollee and will have to wait until the next open enrollment period to enroll. (See **"Open Enrollment"** above). Note: Special rules apply with respect to enrollment of a dependent child pursuant to a National Medical Support Order or a valid court decree that orders dental coverage (See "**Coverage for Children Pursuant to National Medical Support Notice or Valid Court Order"** above.)

Effective Date of Coverage - If the event triggering special enrollment is the Employee's marriage, coverage for those enrolled due to the marriage will become effective on the date of the marriage, subject to active work requirements of the Plan (See **"When Coverage Begins"** above).

If the event triggering special enrollment is the birth, adoption, or placement for adoption of an eligible dependent child, coverage for those enrolled will become effective as of the date of birth, adoption, or placement for adoption as long as the child is enrolled within 31 days from the date of birth, adoption, or placement for adoption.

C. Loss of Eligibility Under Medicaid or CHIP or Eligibility for Premium Assistance (Current Employees Only)

The special enrollment rules also allow current Employees to enroll themselves and eligible dependents without having to wait until the next open enrollment period under the following circumstances:

- If the Employee and his eligible dependents are covered by Medicaid or the State children's health insurance plan ("CHIP") and coverage under such plan is lost due to a loss of eligibility for such coverage, the Employee may enroll himself and his eligible dependents.
- If the Employee and his eligible dependents become eligible for premium assistance with respect to coverage under this Plan under Medicaid or CHIP (including any waiver or demonstration project conducted under or in relation to such plan), the Employee may enroll himself and his eligible dependents.

Special Enrollment Period

To qualify for special enrollment, the Employee and any eligible dependents must enroll within 60 days of the event (**loss of coverage under Medicaid and/or CHIP or eligibility for premium assistance**) that triggers the right to special enrollment. If the

Employee or eligible dependent is not enrolled within this period, then the right to special enrollment will be forfeited. The Employee or eligible dependent will be treated as a Late Enrollee and will have to wait until the next open enrollment period to enroll.

Effective Date of Coverage

If a special enrollment application is submitted in a timely manner, then coverage for a special enrollee who has lost other coverage **under Medicaid or CHIP, or who has become eligible for premium assistance with respect to this Plan,** will generally become effective on the first day of the month coinciding with or following submission of the completed enrollment application and payment of any required contribution. Coverage will be subject to the active work requirements of the Plan (See **"When Coverage Begins"** above).

Special Enrollment for Retirees.

New dependents of Retirees and eligible dependents of Retirees who were not enrolled when first eligible may be able to enroll if the enrolled Retiree experiences a special enrollment event. Coverage will be provided only if a completed special enrollment application is submitted to the Program Administrator by the applicable deadline.

If a Retiree already has family coverage and enrolls an additional eligible dependent during a special enrollment period, then no additional premium will be required. However, Retirees with single coverage must pay the additional premium in order to complete special enrollment for eligible dependents. Below is a description of the special enrollment events and the rules applicable to each.

Special Enrollment Events for Retirees

Enrolled Retirees who acquire new dependents as a result of marriage, birth, adoption/placement for adoption (a "Special Enrollment Event") may make the following changes if a complete benefit change form (and additional information if requested) is submitted to the Program Administrator within 31 days of the Special Enrollment event:

- Marriage – Retiree may add the new spouse and any children who meet the definition of a dependent child (See "Eligibility as a Dependent") solely as a result of the marriage.
- Acquire New Dependent Child – Retiree may add the new child and an existing spouse.

If the eligible dependent is not enrolled within the 31 day period, then the right to special enrollment is forfeited.

Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, or age.

2. Choice of Dentist

Anthem offers a choice of selecting a Dentist from our panel of Participating Dentists or you may choose a Non-Participating Dentist. A list of Participating Dentists can be obtained by accessing Our website at www.anthem.com. You are responsible for verifying whether the Dentist you select is a Participating Dentist. Dentists are regularly added to the panel. Additionally, you should always confirm with the dentist's office that a listed Dentist is still a contracted Participating Dentist.

Dental Benefits

Participating Dentists

A Participating Dentist is a Dentist who has signed a written provider service agreement agreeing to service the program identified in this Certificate. For Covered Services performed by a Participating Dentist, the Maximum Allowed Amount is based upon the lesser of the Dentist's actual charges or the Schedule of Maximum Allowable Charges. Because Participating Dentists have agreed to accept the Maximum Allowed Amount as payment in full for services, they should not send you a bill or collect for amounts above the agreed upon Maximum Allowed Amount. However, you may receive a bill or be asked to pay a portion of the Maximum Allowed Amount to the extent you have exhausted your coverage for the service, have not met your Deductible, have a Coinsurance, have received Non-Covered Services, or have exceeded the dental benefit maximum as outlined in the Summary of Benefits. Please call Our Customer Service Department at (844) 729-1567 for help in finding a Participating Dentist or visit Our website at www.Anthem.com. Anthem will update this listing of providers on at least an annual basis.

Non-Participating Dentists

Dentists who have NOT signed a written provider service agreement agreeing to service the program identified in this Certificate are considered Non-Participating Dentists. For Covered Services you receive from a Non-Participating Dentist, the Maximum Allowed Amount will be the lesser of the Dentist's actual charges or an amount based on Our Non-Participating Dentist fee schedule, referred to as the Table of Allowances, which We have established in Our discretion, and which We reserve the right to modify from time to time after considering one or more of the following: reimbursement amounts accepted by similar providers contracted with Us, and other industry cost, reimbursement and utilization data. The Table of Allowances may be different from the Maximum Allowed Amount reimbursed to Participating Dentists.

Unlike Participating Dentists, Non-Participating Dentists may send you a bill and collect for the amount of the Dentist's charge that exceeds Our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Non-Participating Dentist charges. This amount may be significant. Choosing a Participating Dentist will likely result in lower out of pocket costs to you. Please call Customer Service Department at (844) 729-1567 for help in finding a Participating Dentist or visit Our website at www.Anthem.com.

Customer Service is also available to assist you in determining the Maximum Allowed Amount for a particular service from a Non-Participating Dentist. In order for Us to assist you, you will need to obtain the specific procedure code(s) from your Dentist for the services the Dentist will render. You will also need to know the Dentist's charges to calculate your out of pocket responsibility. Although Customer Service can assist you with this pre-service information, the Maximum Allowed Amount for your claim will be based on the actual claim submitted.

3. Description of Benefits and Services

The 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.

This Plan provides reimbursement for the percentage of Covered Expenses set forth in the Summary above. The Plan's reimbursement does not change the plan of treatment. If you choose to obtain Optional Services, Covered Expenses will be determined based on the cost of the least expensive professionally adequate treatment instead of on the actual cost of the treatment. Anthem has the sole responsibility for determining whether you have received Optional Services, and is authorized to exercise discretion when making this decision in accordance with its clinical guidelines. Some examples of Optional Services are:

- a crown where a filling would restore the tooth;

- a precision denture/partial where a standard denture/partial could be used;
- an inlay/onlay instead of an amalgam restoration;
- porcelain, resin or similar materials for crowns placed on a maxillary second or third molar, or on any mandibular molar (an allowance will be made for a porcelain fused to high noble metal crown); or
- a composite restoration instead of an amalgam restoration on posterior teeth.

You will be responsible for paying any costs that are not considered Covered Expenses, and these additional costs do not count toward Out-of-Pocket Maximums.

Dental Benefits

The date of incurred liability for multi-visit procedures such as root canals, dentures, partial dentures, crowns or bridges will be:

- for an appliance (or change to an appliance), at the time the impression is made;
- for a crown, bridge or cast restoration, at the time the tooth or teeth are prepared;
- for root canal therapy, at the time the pulp chamber is opened; and
- for all other dental services, at the time the service is performed or the supply furnished.

Plan Maximums

The maximum amount the Plan will pay for each enrolled person is shown in the **Summary of Benefits**. All services are limited to this combined yearly maximum per Participant per calendar year. This calendar year maximum does not apply to Orthodontic benefits.

Allowed Amounts

The Maximum Plan Allowance (MPA) is the maximum amount Anthem will reimburse for a covered procedure. For Non-Anthem Dentist, Anthem establishes the MPA for each procedure through a review of proprietary filed fee data and actual submitted claims. MPA's are set annually to reflect charges based on actual submitted claims from providers in the same geographical area with similar professional standing. For dentists contracted with Anthem (either as a PPO Dentist or as a Premier Dentist,) the Allowed Amount is established by contract.

Deductible

You must satisfy the Deductible amount as shown in the **Summary of Benefits** each calendar year. Only amounts paid for Covered Expenses count toward the Deductible.

Carry-over Deductible

Covered Expenses during the last three months of a calendar year applied to that year's deductible can carry over and also apply toward the next year's deductible.

Pre-Treatment Estimate of Benefits

When the anticipated expense for any course of treatment exceeds **$300.00**, it is recommended that you submit to the Claims Administrator a request for a pre- treatment estimate of benefits as prepared by the attending Dentist on the appropriate form before the treatment commences.

The Claims Administrator will estimate the amount of Benefits payable under the Plan for the listed services. By asking your Provider for a Pre-Treatment Estimate before you agree to receive any prescribed treatment, you will have an estimate up front of what the Plan will pay and the difference you will need to pay. The benefits will be processed according to the terms of the Plan and the contract between Anthem and the Provider when the treatment is actually performed. Pre-Treatment Estimates for Anthem Providers are valid for 365 days unless other services are received after the date of the Pre-Treatment Estimate, or until an earlier occurrence of any one of the following events:

- the date Anthem no longer serves as Claims Administrator for the Plan;

- the date benefits under the Plan are amended if the services in the Pre-Treatment Estimate are part of the amendment;
- the date your coverage ends; or
- the date the Provider's agreement with Anthem ends.

A Pre-Treatment Estimate does not guarantee payment. It is an estimate of the amount the Plan will pay if you are enrolled and meet all the requirements of the program at the time the treatment you have planned is completed and may not take into account any Deductibles, so please remember to figure in your Deductible if necessary.

Type 1 - Preventive and Diagnostic Services

The Plan pays benefits for Covered Expenses in accordance with the Summary of Benefits for Type 1 services described below. No deductible is applied for the following services.

Prophylaxis and Routine Oral Examinations
The Plan will allow a maximum of three regular or periodontal cleanings and three routine oral examinations within a 12 month period,; other exams two in a calendar year.

Dental X-rays
Full mouth X-rays and panoramic X-rays, limited to not more than once in any period of 36 consecutive months.
Supplementary bitewing X-rays, limited to not more than twice per calendar year.
Other dental X-rays as required in connection with the diagnosis of a specific condition requiring treatment.

Topical Application of Fluoride
Two treatments per calendar year for Participants under age 19 only. A Dentist or a licensed dental hygienist under the supervision of a Dentist must perform the service.

Space Maintainers
Services to maintain existing space from the premature loss or extraction of deciduous teeth (primary or baby teeth) by means of a fixed or removable appliance designed to prevent adjacent and opposing teeth from moving. Adjustments are covered if required because of relative change in the condition of the mouth; to age 14, once per quadrant; per lifetime.

Diagnostic Casts

Pulp Vitality Testing (one per calendar year) Palliative Treatment
Including emergency exams needed to ease dental pain.

Sealants
Application of sealants to the permanent molars of your covered Dependent child if less than 19 years old. The Plan pays for one application every 3 years.

Dental Benefits

Type 2 - Basic Restorative Services

Before this Plan begins to pay benefits for the Covered Expenses shown in the Summary of Benefits for Type 2 services, a Participant must meet the Deductible required.

Repair of Removable Dentures

Re-cement Crowns and Re-cement Bridges

Simple Extractions, pulling of teeth, including removal by surgery of impacted teeth.

Fillings - Covers both silver amalgam and tooth colored synthetic materials.

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

Medicine or prescribed drugs for dental conditions

General anesthesia or I.V. sedation for oral surgery.

Apicoectomy
Excision of the apex portion of a tooth root.

Occlusal Guards
Limited to one per lifetime.

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

Type 2 – Basic Periodontics Services

Before this Plan begins to pay benefits for the Covered Expenses shown in the Summary of Benefits for Type 2 services, a Participant must meet the Deductible required.

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

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

Gingivectomy and

gingivoplasty

Osseous Surgery
Includes flap entry and closure.

Vestibuloplasty

Type 3 – Major Services

Before this Plan begins to pay benefits for the Covered Expenses associated with Type 3 services described below, a Participant must meet the Deductible required.

Inlays

Crowns

Crowns (not part of a bridge), provided the tooth is not restorable with silver amalgam or tooth colored synthetic restorations. The Dentist or Participant shall be required to submit to the Claims Administrator a pre-operative x-ray with treatment plan showing the need for such crown prior to benefit payment.

Dentures

Includes both full and partial dentures.

Bridges

Fixed and removable bridges, except that:

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

Implants

Implant surgical placement and removal; and for implant supported prosthetics, including implant repair and re-cementation.

Denture Rebase or Reline Repair of Fixed Bridges

Benefits are payable for replacement of one or more natural teeth lost while covered under this Plan.

Type 4 - Orthodontic Services

The Plan pays benefits for Covered Expenses shown for Type 4 services described below. No deductible is applied for the following services.

Lifetime Maximum

There is a lifetime maximum benefit per Participant as shown in the **Summary of Benefits**. This benefit applies to Employee, Spouse and covered Dependent Children under the age of 26.

Initial Diagnosis Procedures

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

Initial Placement of Orthodontic Appliance

Active and Retention Treatments

Claims for such treatments must be filed on a monthly basis.

Dental Benefits

Removal of Teeth

Correction of malocclusion by wire appliances, braces and other mechanical aids.

Special Requirements for Orthodontic Services

All orthodontic services require a treatment plan.

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

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

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

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Dental Benefits

4. Limitations and Exclusions

What's Not Covered

1. Services for which the Participant incurs no charge.
2. Dental service which is the result of an injury or disease for which you are entitled to benefits, in whole or in part, under Workers' Compensation or employer's liability laws.
3. Dental services with respect to congenital tooth malformations or primarily for cosmetic or esthetic purposes unless due to Accidental Injury sustained while you are covered under this Plan.
4. Treatment furnished or available to you in whole or in part under the laws of the United States, or any state, or political subdivision.
5. Treatment for any condition, disease, ailment, injury, or diagnostic service to the extent that benefits are provided, or would have been provided had a claim been filed, under title XVIII of the Social Security Act of 1965 (Medicare), including amendments thereto.
6. Appliances or restorations done specifically to increase vertical dimensions or restore the occlusion.
7. Gold foil restorations.
8. Treatment needed because of diseases contracted, or injuries sustained, as a result of war.
9. Any procedure started while you were not enrolled in this Plan.
10. Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services"), which are, in the Claims Administrator's judgment, experimental or investigational for the diagnosis of the Participant being treated are excluded. Services, which support or are performed in connection with the experimental or investigational services, are also excluded. For purposes of this exclusion, experimental or investigational services include, but are not limited to, any services which at the time they are rendered and for the purpose and in the manner they are being used:
    - have not yet received final U.S. Food and Drug Administration approval for other than experimental, investigational or clinical testing; or
    - are provided under a written protocol or are the same services provided to other patients under a written protocol for the diagnosis; or
    - are determined by the Claims Administrator in consultation with dental advisors to be in a research status prior to general use in the medical community in Georgia. If two or more of the following indicators apply to a service at the time of pre-certification request or claim review, it will be conclusively deemed to be in a research status prior to general use in the medical community in Georgia for purposes of the exclusion:
        - the service is not performed in Georgia;
        - the service is the subject of a Phase I, II or III clinical trial;
        - the service has not been the subject of a study published in peer reviewed medical (or dental) literature. "Peer reviewed medical literature" means a U.S. scientific publication which requires that manuscripts be submitted to acknowledged experts inside or outside the editorial office for their considered opinions or recommendations regarding publication of the manuscript. Additionally, in order to qualify as peer reviewed medical (or

Dental Benefits

What's Not Covered (continued)

dental) literature, the manuscript must actually have been reviewed by acknowledged experts before publication:

11. The replacement of any prosthetic appliance, implant, crown, inlay or onlay within five (5) years of the date of last placement, unless such replacement is required as a result of Accidental Injury sustained while you are covered under this Plan.
12. Periodontal splinting (intracoronal and extracoronal).
13. Charges for education or training in and supplies used for dietary or nutritional counseling, x-ray duplications, cancer screening and personal oral hygiene or dental plaque control.
14. Dental services for which coverage is available to you under any other group (medical/surgical) contract or insurance policy.
15. Charges for treatment by other than a Dentist, except for services rendered by a dental hygienist under the direct supervision of a Dentist.
16. Charges for services or supplies that are cosmetic in nature, including charges for personalization of dentures.
17. Charges for failure to keep a scheduled visit or charges for completion of claim forms.
18. Charges for inpatient hospital care such as room, board, ancillary and other services or facility charges for outpatient hospital/freestanding surgical facility.
19. Charges for any Orthodontic care or appliances in excess of the Lifetime Maximum stated in the Summary of Benefits.
20. Services rendered by a provider who is a close relative or member of your household. Close relative means spouse, parent, child, brother or sister by blood, marriage or adoption.
21. Dental treatment for cosmetic reasons. **Exception:** We pay covered expenses for reconstructive surgery or treatment which is required:
    - because of Accidental Injury which takes place while you or your Dependent are enrolled in this Plan.
    - for a congenital defect of an covered Dependent child born to you or your spouse while insured for Dependent's insurance.
22. Extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
23. Services for any disturbances of the temporomandibular jaw joint (TMJ).

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.

5. Coordination of Group Health and Dental Program Benefits

Any dental services eligible for coverage under your major medical health plan will be payable according to the provisions of that plan. No benefits are provided under this dental Plan for such services.

If an Employee, the Employee's spouse, or the Employee's dependents have duplicate coverage under another group dental plan, any other group dental expense coverage, or any local, state or governmental program, (except school accident insurance coverage and Medicaid) then benefits payable under this Plan will be coordinated with the benefits payable under the other plan. **The total benefits paid by both plans will not exceed 100% of the total charges.** The Plan's liability in coordinating will not be more than 100% of MPA or the Contract Allowance.

Allowable Expense means any necessary, reasonable and customary expense at least a portion of which is covered under at least one of the plans covering the person for whom claim is made. The claim determination period is the calendar year.

Order of Benefit Determination

When a Participant has duplicate coverage, claims will be paid as follows:

- **Automobile Insurance**. Benefits available through automobile insurance coverage will be determined before that of any other plan.
- **Non-Dependent/Dependent**. The benefits of the plan which covers the person as an Employee (other than as a Dependent) are determined before those of the plan which covers the person as a Dependent.
- **Dependent Child/Parents Married.** Except as stated below, when this Plan and another plan cover the same child as a Dependent of different persons, called **"parents"**:
  - The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the other parent's plan.
  - If both parents have the same birthday, the benefits of the plan, which covered the parent longer, are determined before those of the other parent's plan.
  - However, if the other plan does not have the rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
- **Dependent Child/Parents Divorced.** If two or more plans cover a person as a Dependent child of divorced parents, benefits for the child are determined in this order:
  - first, the plan of the parent with custody of the child;
  - then, the plan of the spouse of the parent with the custody of the child; and
  - finally, the plan of the parent not having custody of the child.

    However, if the specific terms of a court decree state that one of the parents is responsible for the child's dental care expenses and the company obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the company has that actual knowledge.

    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 plans covering the child shall follow the order of benefit determination rules outlined above for "Dependent Child/Parents Married."

- **Active/Inactive Employee.** The benefits of a plan that covers a person as an Employee who is neither laid off nor retired (or as that Employee's Dependent) are determined before those of a plan that covers that person as a former Employee (or as that Employee's Dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

- **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the plan, which covered an Employee or Participant longer, are determined before those of the plan that covered that person for the shorter time.

Effect on the Benefits of this Plan

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

Reduction in this Plan's benefits. The benefits of this Plan will be reduced when the sum of:

- the benefits that would be payable for the Allowable Expenses under this Plan in the absence of this COB provision; and
- the benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceed those Allowable Expenses in a claim determination period. In that case, the benefits of this Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

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

Claims Administrator's Rights Related to Coordination of Benefits

- **Right to Receive and Release Necessary Information.** Certain facts are needed to apply these COB rules. The Claims Administrator has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Claims Administrator any facts needed to pay the claim.
- **Facility of Payment.** A payment made under another plan may include an amount which should have been paid under this Plan. If it does, the Claims 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 Plan. The Claims Administrator will not have to pay that amount again.
- **Right of Recovery.** If the amount of the payment made by the Claims Administrator is more that it should have paid under this COB provision, it may recover the excess from one or more of:
  - the persons it has paid or for whom it has paid,
  - insurance companies, or
  - other organizations.

6. Claims

Eligibility Administration

The Program Administrator has discretion to interpret the terms of the Plan that pertain to eligibility for benefits, and the Program Administrator's decision regarding eligibility is final. If you believe that a mistake has been made related to enrollment or eligibility for the Plan, contact the Program Administrator in writing at:

GMEBS Dental Plan Eligibility Appeals
P.O. Box 105377
Atlanta, Georgia 30348

Include copies of all information that supports your assertion. The Program Administrator will review the information you submit and the relevant Plan Documents, and will send you a written response to your request within 45 days. If you disagree with the written response, you may appeal the decision by writing "GMEBS Dental Plan Eligibility Appeals Decision Review" at the above address within ninety (90) days of the date on the written response.

Claims Administration

The Claims Administrator has discretion to interpret the terms of the Plan that pertain to payment of dental claims, and is solely responsible for administering all dental claims and making all decisions related to dental claims.

How to File Claims

Under normal conditions, the Claims Administrator should receive the proper claim form within 90 days after the service was provided. This section of the Booklet describes when to file a benefits claim and when the Dentist will file the claim for you.

Each person enrolled through the Plan receives an Identification Card. When services are provided, the Participant should present his/her Identification Card. The Participant will be billed only for those charges not covered by this Plan.

If a Participant goes to a Dentist or Physician that does not have a Participating Agreement with the Claims Administrator, the Participant should inform the Dentist or Physician of his/her coverage under this Plan. Upon completion, send a copy of the itemized bill to the Claims Administrator. Payment for Covered Expenses will be sent directly to the Enrolled Employee or to the Dentist if an assignment of benefits is provided.

Processing Your Claim

You are responsible for submitting your claims for expenses not normally billed by and payable to a Dentist. Always make certain you have your Identification Card with you.

Dental Benefits

Be sure the Dentist's office personnel copy your name and identification numbers accurately when completing forms relating to your coverage.

If it is necessary for you to have dental services outside Georgia, it may be necessary for the Participant to pay the attending Dentist for his/her services and then submit an itemized statement to the Claims Administrator's office when he/she returns home.

Timeliness of Filing

To receive benefits, a properly completed claim form with any necessary reports and records must be filed by the Participant within 12 months of the date of service. Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information. In this case, you will be notified of the reason for the delay and will receive a list of all information needed to continue processing your claim. After this data is received, the Claims Administrator will complete claims processing.

Necessary Information

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

Unauthorized Use of Identification Card

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

Questions About Coverage or Claims

If you have questions about coverage, contact the Claims Administrator's Customer Service Department. Be sure to always give your ID number.

Information to Provide

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

- Participant ID number;
- Patient name, Employee's name and address;
- Date of service;
- Type of service received; and
- Provider name and address (Hospital or Dentist)

Explanation of Benefits

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

Complaints about Service or Claims

If you wish to contest denial of a dental claim, you can appeal the denial by calling the Customer Service telephone number 1-844-729-1567. Anthem will notify you if benefits are denied for services submitted on a Claim Form, in whole or in part, stating the reason(s) for denial. You have 180 days after receiving a notice of denial to appeal it by writing to Anthem giving reasons why the denial was wrong. You may also ask Anthem to examine any additional information he/she includes that may support

your appeal.

Anthem will make a full and fair review within 15 days after Anthem receives the request for appeal. Anthem may ask for more documents if needed. In no event will the decision take longer than 15 days. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of the Contract, Anthem shall consult with a Dentist who has appropriate training and experience. The review will be conducted for Anthem by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual. The identity of such dental consultant is available upon request whether or not the advice was relied upon.

To Whom Benefits are Paid

PPO Dentists and Premier Dentists will be paid directly. Any other payments provided by the Plan will be made to you, unless you request when filing a claim that the payment be made directly to the Dentist providing the services. All benefits not paid to the Dentist will be payable to you, or to your estate, except that if the person is a minor or otherwise not competent to give a valid release, benefits may be payable to the parent, guardian or other person actually supporting him.

Legal Actions

No action at law or in equity may be brought to recover benefits prior to expiration of 60 days after proof of loss has been filed in accordance with requirements of the Plan, nor may an action be brought at all unless brought within three (3) years from expiration of the time within which proof of loss is required by the Plan.

7. General Conditions and Information

Terms of Your Coverage

The Plan provides the benefits described in this Booklet only for eligible Participants. Reimbursement for expenses associated with dental care services are subject to the limitations, exclusions, Deductible, and Coinsurance requirements specified in this Booklet. Any group dental plan booklet or certificate, which a Participant received previously will be replaced by this Plan Booklet.

Benefit payment for Covered Services or supplies will be made directly to the Participating Dentist or to the Participant depending upon whether services were rendered by a Participating or Non-Participating Provider.

The Plan does not supply you with a Dentist. In addition, neither the Plan nor the Claims Administrator is responsible for any injuries or damages you may suffer due to actions of any Dentist, Hospital or other person. In order to process claims, the Claims Administrator may request additional information about the dental treatment you received and/or other group insurance a Participant may have. This information will be treated confidentially.

Verbal Explanation Not Binding

A verbal explanation of your benefits by an employee of the Claims Administrator, Plan Administrator, Plan Sponsor or Participating Employer is not legally binding.

Dental Benefits

Update Your Address

Any correspondence mailed to Participants will be sent to the most current address for the Participant as shown in the records of the Plan, which are maintained by the Program Administrator. Participants are responsible for providing accurate and complete mailing address information upon their enrollment in the Plan, and for promptly notifying the Program Administrator of any change in their address. If a covered dependent has a different mailing address than that of the Employee, the Program Administrator must be notified of such different mailing address upon enrollment of the dependent and/or when the dependent obtains such different mailing address, as applicable.

Fraudulent Statements

Fraudulent statements on enrollment forms or documents provided to the Program Administrator or the Claims Administrator will invalidate any payment or claims for services and be grounds for voiding the Employee's coverage.

Legal Compliance

The Claims Administrator will comply with all state and federal laws that apply to administration of dental claims. The Claims Administrator does not assume any responsibility for compliance with laws that apply to the Plan Sponsor or the Program Administrator as a result of their duties and the services they perform for the Plan.

Changes in Coverage, Benefits

The booklet should not be construed as creating any vested rights to benefits in favor of any person. Any of the provisions or benefits of the Plan may be amended, curtailed, or terminated at any time without prior notice.

Acts Beyond Reasonable Control (Force Majeure)

The Plan Sponsor, Program 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. 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.

8. When Coverage Terminates and COBRA Continuation Coverage

When Coverage Terminates for Current Employees and Their Dependents

Coverage for a current Employee will end on the earliest of:

- The end of month in which the Employee no longer meets the definition of a Regular Employee or is no longer an elected or appointed member of the Participating Employer's governing authority, or no longer serves as a chief or associate legal officer or municipal judge;
- The termination of the Employee's status as a "Full-Time Employee" as defined by the Affordable Care Act, if coverage was offered to the Employee solely as a result of the Employer's determination that the Employer is an "Applicable Large Employer" (as defined by the Affordable Care Act) and the Employee met the definition of a "Full-Time Employee" under the Affordable Care Act.
- The end of the last period for which a required Employer or Employee contribution is paid
- The date the Participating Employer no longer participates in the Plan.
- The date the Plan is terminated by the Plan Sponsor; or
- The date coverage is terminated for a class of persons to which the Employee belongs.

Coverage for an eligible dependent of a current Employee will end on the earliest of:

- The date the Employee's coverage ends for any reason;
- The end of the month in which the dependent no longer qualifies for dependent coverage under the Plan (e.g., due to divorce from Employee or due to an eligible dependent child reaching age 26 or otherwise losing status as an eligible dependent); or
- The date coverage is terminated for a class of persons to which the dependent belongs.

When Coverage Terminates for Retirees and Their Dependents

Coverage for a Retiree will end on the earliest of:

- The end of the month in which the Retiree turns age 65 or becomes eligible for Medicare (unless the Participating Employer's Retiree Coverage Declaration Page expressly states otherwise);
- The end of the last period for which the required Employer and Employee contributions are paid;
- The date the Participating Employer no longer offers Retiree Coverage in the Plan;

- The date the Participating Employer no longer offers the Plan to current Employees;
- The date the Plan is terminated by the Plan Sponsor;
- The date Retiree Coverage is terminated by the Plan Sponsor; or
- The date coverage is terminated for a class of persons to which the Retiree belongs.

Unless expressly stated otherwise in the Participating Employer's Retiree Declaration Page, coverage for an eligible dependent of a Retiree will end on the earliest of:

- The date the Employee's coverage ends for any reason;
- The end of the month in which the dependent no longer qualifies for dependent coverage under the Plan (e.g., due to divorce from the Retiree or due to an eligible dependent child reaching age 26 or otherwise losing status as an eligible dependent); or
- The date coverage is terminated for a class of persons to which the dependent belongs.

COBRA Continuation Coverage

COBRA Continuation Coverage for Current Employees and their Dependents

Under the federal COBRA law, employers are required to give enrolled employees and dependents the opportunity to elect a temporary extension of health coverage (referred to as "COBRA" coverage) when their regular coverage would otherwise end due to certain "qualifying events."

You must have been actually enrolled in the Plan on the day before your qualifying event to be eligible for COBRA coverage (except for newborn and adopted children born or placed for adoption within the COBRA coverage period - see below). The Program Administrator reserves the right to verify COBRA eligibility status and to terminate COBRA coverage retroactively if you are determined to be ineligible for COBRA, or if there has been a material misrepresentation of the facts in connection with your coverage.

COBRA Qualifying Events for Enrolled Current Employees

Enrolled current Employees may elect COBRA continuation coverage if they lose their regular coverage due to the following:

- Termination of employment with the Participating Employer (for reasons other than gross misconduct); or
- A reduction in their hours of employment.

COBRA Qualifying Events for Enrolled Dependents of Current Employees

Enrolled dependents may elect COBRA continuation coverage if their regular coverage under the Plan ends because:

- The Employee's employment with the Participating Employer is terminated (for reasons other than gross misconduct);

- The Employee's hours of employment are reduced;
- The Employee dies;
- The Employee is divorced from the enrolled dependent spouse (note – if the Employee reduces or eliminates coverage for the dependent spouse in anticipation of divorce, and the divorce later occurs, then the divorce may be considered a qualifying event even if the spouse was not enrolled at the time of the divorce); or
- The enrolled dependent child no longer qualifies as an eligible dependent.

COBRA Continuation Coverage for Dependents of Retirees

Retirees are not able to continue coverage under COBRA once their coverage as a Retiree in the Plan ends. Enrolled Dependents of Retirees may elect COBRA continuation coverage if their coverage under the Plan ends due to certain "qualifying events."

You must have been actually enrolled in the Plan on the day before your qualifying event to be eligible for COBRA coverage (except for newborn and adopted children born or placed for adoption within the COBRA coverage period - see below). The Program Administrator reserves the right to verify COBRA eligibility status and to terminate COBRA coverage retroactively if you are determined to be ineligible for COBRA, or if there has been a material misrepresentation of the facts in connection with your coverage.

COBRA Qualifying Events for Enrolled Dependents of Retirees

Enrolled dependents of Retirees may elect COBRA coverage if their coverage under the Plan ends because:

- The Retiree turns age 65 or becomes eligible for Medicare
- The Retiree dies
- The Retiree is divorced from the enrolled dependent spouse (note – if the Retiree reduces or eliminates coverage for the dependent spouse in anticipation of divorce, and the divorce later occurs, then the divorce may be considered a qualifying event even if the spouse was not enrolled at the time of the divorce); or
- The enrolled dependent child no longer qualifies as an eligible dependent.

Required Notifications

Required Notifications for Current Employees and Their Dependents

Under COBRA, enrolled current Employees and their dependents have the responsibility to provide the Program Administrator with written notice of **divorce or of a child losing eligible dependent status under the Plan.** This notification must be made within 60 days from the date of the event or, if later, the date on which health plan coverage would be lost under the terms of the Plan because of the qualifying event. If this notice is not provided in a timely manner, then any rights to COBRA coverage will be forfeited. Failure to provide such notice may also result in removal or cancellation of coverage under the plan. See the Notice Page in the front of this booklet for the Program Administrator's contact information.

The Participating Employer is responsible to notify the Program Administrator of the other qualifying events listed above (e.g., Employee's loss of eligibility for coverage due

to death or due to termination of employment or reduction in hours).

Required Notifications for Retirees and Their Dependents

Under COBRA, enrolled Retirees and their dependents have the responsibility to provide the Program Administrator with written notice of **death, attainment of age 65 for the Retiree, the Retiree's enrollment in Medicare, divorce, and loss of a child's status as an eligible dependent.** This notification must be made within 60 days from the date of the event or, if later, the date on which health plan coverage would be lost under the terms of the Plan because of the qualifying event. If this notice is not provided in a timely manner, then any rights to COBRA coverage will be forfeited. Failure to provide such notice may also result in removal or cancellation of coverage under the plan.

60-Day COBRA Election Period

Once the Program Administrator receives notice of a COBRA qualifying event, the Program Administrator will in turn notify COBRA-eligible individuals (also known as "qualified beneficiaries") of their right to elect COBRA continuation coverage. Each qualified beneficiary has independent COBRA election rights and will have 60 days to elect COBRA continuation coverage. The 60-day election period begins on the date health plan coverage is lost due to the qualifying event, or if later, the date the qualified beneficiary is sent a notice about his right to elect COBRA coverage. This is the maximum period allowed to elect COBRA, and the Plan does not provide for an extension of the COBRA election period beyond what is required by law. If a qualified beneficiary does not elect COBRA continuation coverage within this 60-day election period, then all rights to COBRA coverage will be forfeited.

Nature of COBRA Coverage

COBRA coverage is identical to the coverage provided under the Plan to similarly situated Current Employees, or, for Retiree dependents, COBRA coverage is identical to the coverage provided under the Plan to Retirees. Should coverage change or be modified for similarly situated Current Employees (or, for similarly situated Retirees), then the change and/or modification will be made to your COBRA coverage as well.

COBRA Coverage for Current Employees and Dependents – Comparison to Retiree Coverage under this Plan

Some Participating Employers currently offer Retiree coverage under this Plan. Retiree coverage may or may not be subsidized by the Participating Employer. Contact your Participating Employer for information about whether Retiree coverage is available and how much it costs. If your Participating Employer offers Retiree coverage, it is important to understand the difference between continuing coverage as an active employee under COBRA and electing Retiree coverage under this Plan.

COBRA qualified beneficiaries who elect COBRA due to the termination or reduction in hours of a Current Employee:

- have the same special enrollment rights and open enrollment rights as Current Employees;
- can choose any Plan option that is available to Current Employees; and
- may add dependents based on the special enrollment rights and open enrollment rules for Current Employees.

In contrast, Retirees:

- are only allowed to add new dependents based on more limited special enrollment and open enrollment rights, and
- may only choose those Plan options that are available to Retirees.

If you elect coverage as a Retiree or as a dependent of a Retiree under this Plan, you waive the COBRA rights that arose due to the termination of employment of the Current Employee.

Similarly, if you choose COBRA coverage, you will not be able to elect Retiree coverage under this Plan at a later date. It is possible for the former employee to elect Retiree coverage and for his or her dependents to elect COBRA coverage instead.

COBRA Coverage Period

18 Month Events (for Current Employees and their Dependents Only)

If the qualifying event causing a qualified beneficiary's loss of regular coverage is termination of employment (other than for reasons of gross misconduct) or a reduction in work hours, then the qualified beneficiary will have the opportunity to elect COBRA coverage for up to 18 months.

- Extension of 18- Month Period for Social Security Disability
  If a qualified beneficiary is determined by the Social Security Administration to have been disabled at any time during the first 60 days of COBRA coverage, the qualified beneficiary (and any other members of the family receiving COBRA coverage) may apply for an 11-month extension of the normal COBRA coverage period, (i.e., from 18 to 29 months). The purpose of this provision is to allow disabled qualified beneficiaries to continue their COBRA coverage until they become entitled to Medicare. The Plan may charge up to 150% of the normal COBRA premium for months 19 through 29. To qualify for this extension, you must obtain the disability determination from the Social Security Administration and provide a copy of the determination to the Program Administrator within 60 days after the date of determination and before the normal 18-month COBRA period expires. It is also your responsibility to notify the Program Administrator within 30 days of any final determination by the Social Security Administration that you or any qualified beneficiary in your family is no longer disabled.

- Extension of 18-Month Period for Secondary Events
  The 18-month COBRA period can also be extended for spouses and dependents if, during their first 18 months of COBRA coverage, they experience a second COBRA qualifying event (Employee divorce or death, or a dependent child ceasing to be an eligible dependent). If one of these events occurs, then the 18 month COBRA coverage period can be extended to 36 months. It is the qualified beneficiary's responsibility to provide written notification to the Program Administrator within 60 days of a second qualifying event and before the original 18 month COBRA period expires. Failure to provide such written notice will result in denial of extended COBRA coverage. In no event will COBRA coverage last more than 36 months.

36 Month Events (for Current Employees and their Dependents, and for Dependents of Retirees)
If the original qualifying event causing a qualified beneficiary's loss of regular coverage is the Employee's death, divorce, attainment of age 65 or entitlement to Medicare, or a dependent child's ceasing to qualify as an eligible dependent under the plan, then the qualified beneficiary (Current Employee, Dependents of Current Employees, and Dependents of Retirees) may elect COBRA coverage for up to 36 months as set forth in the summary below.

If your coverage was terminated in anticipation of a divorce from the Current Employee or Retiree that was not yet final, contact the Program Administrator when the divorce is final to determine whether you have COBRA rights based on the divorce.

COBRA Coverage Summary

Initial Qualifying Event that Causes Loss of Coverage	Length of Availability of COBRA Coverage
For Current Employees: Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours	Up to 18 months
For Dependents of Current Employees: A Covered Current Employee's Voluntary or Involuntary Termination (other than for gross misconduct) or Reduction in Hours	Up to 18 months
Medicare entitlement of Current Employee, followed by Voluntary or Involuntary Termination (for other than gross misconduct), or Reduction in Hours within 18 months	Up to 36 months from the date of Medicare entitlement
Divorce from Covered Current Employee	Up to 36 months
Death of a Covered Current Employee	Up to 36 months
For Dependent Children of Current Employees: Loss of Dependent Child status	Up to 36 months
For Retirees: No COBRA Coverage is available	No COBRA Coverage after coverage as Retiree ends

Dental Benefits

For Dependents of Retirees:	
A Covered Retiree attains age 65/becomes eligible for Medicare	Up to 36 months
Divorce from Covered Retiree	Up to 36 months
Death of Covered Retiree	Up to 36 months

Newborn and Adopted Children

A child who is born to, adopted by, or placed for adoption with a COBRA covered former employee while the former covered employee is receiving COBRA coverage may obtain COBRA coverage. To enroll the child, the former employee must submit an enrollment form to the Program Administrator within 31 days of the birth or placement for adoption. However, the newborn or adopted child's COBRA coverage cannot be extended beyond the date that the former employee's COBRA coverage ends, unless the child experiences a second COBRA qualifying event. (See "Extension for Secondary Events" above).

Eligibility and Premiums

A qualified beneficiary will have to pay a monthly COBRA premium which may be adjusted from time to time. The COBRA premium is established by the Program Administrator and cannot exceed 102% of the applicable premium (combined employer/employee premium) charged for active employees with similar coverage. If COBRA coverage is extended from 18 months to 29 months due to a Social Security disability, you may be charged up to 150% of the applicable premium during the extended coverage period. There is a maximum grace period of 30 days for the regular monthly COBRA premiums. However, this grace period does not apply to the initial COBRA premium (see below).

Within 45 days after you timely elect COBRA coverage, you must pay the initial COBRA premium. The initial COBRA premium includes the period of coverage from the date you lost coverage through the date of your COBRA election. It also includes any regular monthly premium that becomes due between your election and the end of the 45-day period. There is no grace period for receipt of the initial COBRA premium. If you do not pay the initial premium within 45 days of your election, you will not receive any COBRA coverage.

It is the employees'/dependents' responsibility to pay COBRA premiums to the Participating Employer. If COBRA premiums are not paid by the first of the month for which the coverage is effective, the Participating Employer will notify the Program Administrator and coverage will be suspended until the COBRA premiums are paid. The Participating Employer must notify the Program Administrator to reinstate coverage if the COBRA premium is paid after the due date and before the end of the grace period. COBRA coverage must be continuous. There can be no break in coverage or reinstatement of COBRA coverage after it ends. If COBRA premiums are not paid and the grace period expires, COBRA coverage will be forfeited retroactive to the last period for which the applicable required premium was timely paid.

Termination of COBRA Coverage

COBRA coverage will end on the earliest of:

- The last period for which a COBRA continuation premium is paid in a timely manner;

- The date a qualified beneficiary becomes covered under another group health plan after electing COBRA coverage. This rule will not apply in certain limited circumstances (i.e., where the group health plan is a "grandfathered" plan under the Patient Protection and Affordable Care Act of 2010 ("PPACA") and the group health plan imposes an exclusion or limitation with respect to any pre- existing condition of the beneficiary). However, the rule will apply if the pre-existing condition exclusion or limitation is inapplicable or is satisfied by reason of the Health Insurance Portability and Accountability Act of 1996;
- The date a qualified beneficiary enrolls in Medicare (Part A or B);
- With respect to a qualified beneficiary who extends COBRA coverage to 29 months due to a Social Security disability, the date a final determination is made by the Social Security Administration that the qualified beneficiary is no longer disabled.
- The date the Participating Employer ceases to provide any group health plan to any of its employees.
- The date the Plan is terminated; or
- The date the qualified beneficiary exhausts the applicable maximum COBRA coverage period.
- The date the Participating Employer no longer participates in the Plan.

Initial COBRA Notice

VERY IMPORTANT
INITIAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS
GMEBS Health Plan Offered by Your Employer (the Employer)

To: Enrolled Employee and Enrolled Dependents Living at Employee's Address

Under the federal COBRA law, covered employees and dependents have the opportunity to elect a temporary extension of health coverage ("COBRA") when their coverage would otherwise end under a Georgia Municipal Employees Benefit System (GMEBS) Health Plan due to certain "qualifying events." This notice is intended to inform you (and your covered dependents, if any) in a summary fashion of your potential **future** options and obligations under the continuation coverage provisions of the COBRA law.

It is important that all covered individuals in your family take the time to read this notice carefully and be familiar with its contents. **If you have any covered dependents who are not living at your home address, please provide written notification of the covered dependent's mailing address to Georgia Municipal Association (GMA), COBRA Administrator, at the address below so this notice can be sent to them as well.**

Keep GMA and the Employer Informed of Address Changes
In order to protect your and your family's rights, you should notify GMA and The Employer in writing of any changes in your address and the addresses of family members:

GMA, COBRA Administrator GMEBS Life & Health Fund
P.O. Box 105377
Lifeandhealthadministration@gacities.com Fax: 678-651-1036

Dental Benefits

You're getting this notice because you recently gained coverage under the Georgia Municipal Employee Benefits System (“GMEBS”) Health Plan offered by the Employer (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end. This notice explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA coverage. COBRA (and the description of COBRA coverage contained in this notice) applies only to the group health plan benefits offered by the Employer that are administered by GMA, the Program Administrator and COBRA Administrator for GMEBS, and not to any other benefits offered by the Employer or administered by GMA.

The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you, your spouse, and children when their coverage under the Plan would otherwise end. This notice does not fully describe COBRA coverage or other rights under the Plan. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Benefits Booklet. The Benefits Booklet is available at no charge from the Employer or from GMA. It is posted on the GMA website at http://gacities.com/lhforms when you choose the Employer from the drop-down list of employers under “Benefit Documents.”

The Plan provides no greater COBRA rights than what COBRA requires for governmental plans—nothing in this notice is intended to expand your rights beyond COBRA's requirements for governmental plans.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees.

What Is COBRA Coverage?
COBRA coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event occurs and any required notice of that event is properly provided to the Employer, COBRA coverage must be offered to each person losing Plan coverage who is a “qualified beneficiary.” You, your enrolled spouse, and your enrolled children could become qualified beneficiaries and would be entitled to elect COBRA continuation coverage under the Plan if coverage under the Plan is lost because of the qualifying event. Certain newborns, newly adopted children, and children receiving coverage through a National Medical Child Support Order may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below. Under the Plan, qualified beneficiaries who elect COBRA coverage must pay for it.

Who Is Entitled to Elect COBRA?
If you're an employee, you'll be entitled to elect COBRA if you lose your group health coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll be entitled to elect COBRA if you lose your group health coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct; or
- You become divorced from your spouse.
- Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce later occurs, then the divorce may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce.

A person enrolled as the employee's dependent child will be entitled to elect COBRA if he or she loses group health coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The child stops being eligible for coverage under the Plan as a "dependent child."

How Will I Know When COBRA Coverage is Available?

When the qualifying event is the end of employment or reduction of hours of employment or death of the employee, the Employer will notify GMA, and GMA will send a COBRA election notice and COBRA Election Form to you at the address on file. If you provide GMA notice of a divorce or dependent child's loss of eligibility by the required deadline, GMA will send a COBRA election notice and a COBRA Election Form to the address on file.

You Must Notify GMA of Divorce or Loss of Eligibility for a Dependent Child No Later than 60 Days after Losing Eligibility Due to the Event. (IMPORTANT, TIME-SENSITIVE OBLIGATION FOR EMPLOYEE, SPOUSE, AND DEPENDENT CHILDREN)

A COBRA election will be available to you based on a qualifying event of divorce or loss of dependent child status only if you notify GMA in writing within 60 days after the later of (1) the date of the divorce or child's loss of eligibility as a dependent child; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. **Carefully read the dependent eligibility rules contained in your GMEBS Health Plan Benefits Booklet** (available at http://gacities.com/lhforms by selecting the employer from the drop-down menu under Benefit Documents**) so that you understand when a dependent ceases to be an eligible dependent under the terms of the Plan.** In providing this notice, you must use the Plan's form entitled **"Notice of Qualifying Event Form"** (you may obtain a copy of this form from the Employer at no charge, or you can download the form at http://gacities.com/lhforms and you must follow the notice procedures specified in the box at the end of this notice entitled "Notice Procedures." If these procedures are not followed or if the notice is not provided to GMA during the 60-day notice period, THEN ALL QUALIFIED BENEFICIARIES WILL LOSE THEIR RIGHT TO ELECT COBRA.

Dental Benefits

Electing COBRA
Each qualified beneficiary will have an independent right to elect COBRA. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their children. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA.

How Long Does COBRA Coverage Last?
COBRA coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive up to a maximum of 36 months of coverage. These “36-month events” include the death of the employee, the covered employee's divorce, or a dependent child's losing eligibility as a dependent child.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA coverage for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA coverage generally can last for only up to a total of 18 months. The COBRA coverage periods described above are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage periods described in this notice for several reasons, which are described in the Plan's Benefits Booklet.

There are also ways (described in the following paragraphs) in which the period of COBRA coverage resulting from a termination of employment or reduction of hours can be extended.

Disability extension of COBRA coverage
If a qualified beneficiary is determined by Social Security to be disabled and you notify GMA in a timely fashion, all of the qualified beneficiaries in your family may be entitled to get up to an additional 11 months of COBRA coverage, for a maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above).

The disability extension is available only if you notify GMA of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date of the covered employee's termination of employment or reduction of hours; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension. In providing this notice, you must use the Plan's form entitled “Notice of Disability Form” (you may obtain a copy of this form from the Employer or GMA at no charge or you can download the form at http://gacities.com/lhforms, and you must follow the procedures specified in the box at the end of this notice entitled “Notice Procedures.” If these procedures are not followed or if the notice is not provided to GMA during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.

Second qualifying event extension of COBRA coverage
If your family experiences another qualifying event while receiving COBRA coverage because of the covered employee's termination of employment or reduction of hours (including COBRA coverage during a disability extension period as described above), the spouse and dependent children receiving COBRA coverage can get up to 18 additional months of COBRA coverage for a maximum of 36 months, if GMA is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA coverage if the employee or former employee dies; gets divorced; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. (This extension is not available under the Plan when a covered employee becomes entitled to Medicare after his or her termination of employment or reduction of hours.)

This extension due to a second qualifying event is available only if you notify GMA in writing of the second qualifying event within 60 days of the date of the second qualifying event.

In providing this notice, you must use the Plan's form entitled “Notice of Second Qualifying Event Form” (you may obtain a copy of this form from the Employer at no charge, or you can download the form at http://gacities.com/lhforms), and you must follow the procedures specified in the box at the end of this notice entitled “Notice Procedures.” If these procedures are not followed or if the notice is not provided to GMA during the 60-day notice period, THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.

More Information About Individuals Who May Be Qualified Beneficiaries
Children born to or placed for adoption with the covered employee during COBRA coverage period
A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts as long as COBRA

coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise-applicable Plan eligibility requirements (for example, regarding age).

Children enrolled pursuant to National Medical Child Support Order
A child who is receiving benefits under the Plan pursuant to a National Medical Child Support Order received by the Employer during the covered employee's period of employment with the Employer is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

Are There Other Coverage Options Besides COBRA Coverage?
Yes. Instead of enrolling in COBRA coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare Part B and elect COBRA coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA coverage and later enroll in Medicare Part A or B before the COBRA coverage ends, the Plan may terminate your COBRA coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information, visit https://www.medicare.gov/medicare-and-you.

Can I enroll in a Retiree Health Plan after my group health plan coverage ends?
Some employers permit retirees to re-enroll in the group health plan as a retiree, or to enroll in a separate retiree health plan after coverage as an active employee has terminated due to retirement. Contact the Employer employee responsible for health benefits to ask if this option is available and to review any enrollment forms that may apply. In most cases, such retiree coverage is an alternative to COBRA coverage for the retiree and will waive COBRA rights for the retiree.

If you have questions
If you have any questions about your COBRA rights and obligations, or if you do not understand any part of this COBRA notice, please contact lifeandhealthadministration@gacities.com or call 678-651-1039. This notice does not fully

describe continuation coverage or other rights under the Plan. Details of COBRA rights and requirements are set forth in the COBRA section of the Benefits Booklet. If you want a free copy of your Benefits Booklet, you should contact the employee responsible for health benefits at the Employer or GMA or download it from the GMA website as described above. Individuals seeking more information about rights under COBRA for governmental plan enrollees should visit https://www.cms.gov/CCIIO/Programs-and- Initiatives/Other-Insurance-Protections/cobra_qna.

Notice Procedures
Notices Must Be Written and Submitted on Plan Forms: Any notice that you provide must be in writing and submitted on the Plan's required form to the address below. (The Plan's required forms are described above in this notice, and you may obtain copies from the Employer without charge or download them at http://gacities.com/lhforms.)

Where to Send Notices:
GMA, GMEBS COBRA Administrator P.O. Box 105377 Atlanta, GA 30348/Fax: 678-651-1036

When to Send Notices: Your notice must be postmarked or faxed no later than the last day of the applicable notice period described above. ***If you ask someone else (such as the employer) to send the notice to GMA on your behalf, obtain and keep a copy of proof that the notice was sent to GMA by the deadline.***

Information Required for All Notices: Any notice you provide must include: (1) the name of the Plan (GMEBS Health Plan offered by the Employer); (2) the name and address of the employee who is (or was) covered under the Plan; (3) the name(s) and address(es) of all qualified beneficiary/ies who lost coverage as a result of the qualifying event; (4) the qualifying event and the date it happened; and (5) the certification, signature, name, address, and telephone number of the person providing the notice.

Additional Information Required for Notice of Qualifying Event: If the qualifying event is a divorce, your notice must include a copy of the decree of divorce. If your coverage is reduced or eliminated and later a divorce occurs, you must notify GMA of the divorce and provide evidence satisfactory to GMA that your coverage was reduced or eliminated in anticipation of the divorce.

Additional Information Required for Notice of Disability: Any notice of disability that you provide must include: (1) the name and address of the disabled qualified beneficiary; (2) the date that the qualified beneficiary became disabled; (3) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (4) the date that the Social Security Administration made its determination; (5) a copy of the Social Security Administration's determination; and (6) a statement whether the Social Security Administration has subsequently determined that the disabled qualified beneficiary is no longer disabled.

Additional Information Required for Notice of Second Qualifying Event: Any notice of a second qualifying event that you provide must include: (1) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (2) the second qualifying event and the date that it happened; and (3) if the second qualifying event is a divorce, a copy of the decree of divorce.

Who May Provide Notices: The covered employee (i.e., the employee or former employee

who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the qualifying event described in the notice, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

9. Definitions

Application for Enrollment or Enrollment Form
The original and any subsequent forms completed and signed by the Employee seeking coverage or changes to coverage under this Plan. All Enrollment Forms and Benefit Change Forms are posted at www.gmanet.com/lhforms.

Claims Administrator
The company the Plan Sponsor chose to administer claims for dental benefits. Anthem Insurance Company (Anthem) Inc. was chosen to administer claims under this Plan.

Coinsurance
A percentage of the Maximum Allowed Amount for which you are responsible to pay. Your Coinsurance will not be reduced by refunds, rebates, or any other form of negotiated post-payment adjustments.

Coordination of Benefits
A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for dental care or treatment. It avoids claim payment delays by establishing an order in which plans pay their claims and provides authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision; it does not have to pay its benefits first.

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

Dental Benefits

- For all Participating Providers, any charge in excess of the Contract Allowance or
- For all Non-Participating Providers, any charge by a Dentist in excess of the Maximum Plan Allowance.
- For all Providers, the charges for an Optional Service that exceed the charge for the least expensive professionally adequate treatment, as determined by the Claims Administrator in its sole discretion.

Covered Services
Services or treatment as described in this Booklet which are performed, prescribed, directed or authorized by a Dentist. To be considered Covered Services, services must be:

- Within the scope of the license of the Provider performing the service;
- Rendered while you are enrolled in the Plan
- Not specifically excluded or limited by this Booklet; and
- Specifically included as a benefit in this Booklet..

Deductible
The dollar amount of Covered Services listed in the Summary of Benefits for which you are responsible before the Plan starts to pay for Covered Services each PlanYear.

Participating Dentist
A Dentist who has signed a written provider service agreement agreeing to service the program identified in this Certificate. The Dentist has agreed to accept ANTHEM's Schedule of Maximum Allowable Charges as payment in full for dental care covered under this Certificate.

Dentist
A person who is licensed to practice dentistry by the governmental authority having jurisdiction over the licensing and practice of dentistry.

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

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

Identification Card
A card issued by the Plan, showing the Member’s name, membership number, and occasionally coverage information.

Lifetime Maximum Benefit
The Lifetime Maximum Benefit includes all payments made under this Plan. All services and all calendar year maximums whether for a number of days or visits, treatments or a yearly dollar limit, are subject to the Lifetime Maximum Benefit.

Dental Benefits

Non-Participating Dentist
A Dentist who has NOT signed a written provider service agreement agreeing to service the program identified in this Certificate. ANTHEM will reimburse Non-Participating Dentists according to the Maximum Allowed Amount for Non-Participating Dentists, also referred to in this Certificate as the Table of Allowances. The Table of Allowances may be different from the Maximum Allowed Amount reimbursed to Participating Dentists.

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

Participating Employer
An Employer who is eligible to participate as a member employer in the Georgia Municipal Employees Benefit System Health Plan and who has completed the documents required by the Program Administrator for participation in the Plan.

Plan
The arrangement chosen by the Plan Sponsor to fund and provide for delivery of group dental benefits to eligible Employees of Participating Employers, as set forth in the Participating Employer's Declaration Page and Retiree Coverage Declaration Page (if applicable.)

Plan Documents
The documents that contain the terms and conditions of the Plan. These documents include the State statutes that establish the Plan Sponsor, and your Employer's Declaration Pages pertaining to this Plan that are filed with and accepted by the Program Administrator. These Declaration Pages describe which individuals are eligible for the Plan. Plan Documents also include documents that set forth the premiums you must pay to the Employer for participation in the Plan. These employee premium documents are maintained solely by the Employer, and are not approved by the Plan Sponsor or Program Administrator. Plan Documents include clinical guidelines that the Claim Administrator follows when administering claims. The terms and conditions of the Plan are summarized in this Booklet. In the event of ambiguity or conflict between this Booklet and the Plan Documents, the Plan Documents control.

Plan Sponsor
Georgia Municipal Employees Benefit System (GMEBS) is the Plan Sponsor.

You or Your
Refers to the Employee Participant and/or each Covered Dependent as applicable.

Effective 1/1/2025
GMEBS/LH-Dental