EMPLOYEE DENTAL PLAN

Summary Plan Description

For coverage effective February 1, 2021

Dental Insurance
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Dental Insurance
Summary Plan Description

Name of the Plan:	Core Management Resources Group, Inc. Employee Dental Plan
Type of Plan:	Self-Insured Welfare Plan providing dental benefits.
Type of Administration:	Contract Administration with the Third Party Administrator.
Address of the Plan:	515 Mulberry Street, Suite 300 Macon, GA 31201
Plan Number:	100300A & Z
Group Number:	130-132
Plan Sponsor:	Core Management Resources Group, Inc.
Federal Tax ID#:	58-2314468
Plan Effective Date:	February 1, 1988
Plan Renewal Date:	February 1st
Plan Fiscal Year Ends:	January 31st
Third Party Administrator:	Core Administrative Services PO Box 90 Macon, GA 31202-0090 (478) 741-3521 (888) 741-2673
Named Fiduciary:	Core Management Resources Group, Inc.
Agent for Service of Legal Process:	Core Management Resources Group, Inc.
Waiting Period:	Sixty (60) days from the date of hire.
Effective Date of Coverage:	First of the month following the waiting period.
Termination Date of Coverage:	Last day of the month termination is effective. If termination is effective on the last day of the month, coverage is terminated that day.
Contributions:	Both Employer and the Employee contribute towards the cost of coverage. Specific employee rates may be obtained from the Benefits Administrator or CAS.

Introduction

This Employer has retained the services of an independent Third Party Administrator, Core Administrative Services (CAS), experienced in claims processing to handle claims.

The Plan Sponsor assumes the sole responsibility for funding the employee benefits out of general assets. The Plan is intended to comply and be governed by the "Employee Retirement Income Security Act of 1974" as amended (ERISA) and not state law. Therefore, state law governing guarantee funds may not cover benefits payable under the Plan if the Plan Sponsor is unable to pay benefits. The Plan Sponsor has purchased excess risk insurance coverage which is intended to reimburse the Plan Sponsor for certain losses incurred and paid under the Plan by the Plan Sponsor. The excess risk insurance coverage is not a part of the Plan.

This booklet, the Group Provisions Pages, and any amendments constitute the Plan Document for the Employer's benefit plan. This Plan is maintained for the exclusive benefit of the employees and each employee's rights under this Plan are legally enforceable. The Employer has the right to amend the Plan at any time, and will make a "good faith" effort to communicate to you all such changes which affect benefit payment. Amendments or modifications which affect you will be communicated to you within sixty (60) days of the effective date of a modification or amendment. Requests for exceptions to the Plan must be submitted in writing to the Plan Administrator prior to receiving the service and/or supply.

The following pages of this booklet include: the requirements for being covered under This Plan, the provisions concerning termination of coverage, a description of the Plan benefits (including any limitations and exclusions), and the procedures to be followed in presenting claims for benefits and the appeal process for any claim that may have been denied.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relative to a Plan Participant’s rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

The Plan Administrator has the discretionary authority to decide whether a charge is Reasonable and Customary. Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

Some of the terms used in the booklet begin with a capital letter. These terms have a special meaning under the Plan and they are listed in the Plan Payment Provision or Definitions section. When reading the provisions of the Plan, it may be helpful to refer to these sections. Becoming familiar with the terms defined there will give you a better understanding of the procedures and benefits described. Benefits are not contractually guaranteed.[1]

You are entitled to this coverage if you are eligible in accordance with the provisions in this booklet. This booklet is void if you have ceased to be entitled to coverage. No clerical error will invalidate your coverage if otherwise validly in force, nor continue coverage otherwise validly terminated.

If a clerical error occurs, the Employer reserves the right to make any corresponding contribution adjustment which will be computed on the basis of the contribution level then in effect. If any clerical error occurs in this document, the most current Employer signed Plan Document prevails. If you have any questions concerning your eligibility or benefits please contact:

Core Administrative Services
PO Box 90
Macon, GA 31202

478-741-3521
888-741-CORE (2673)

Comprehensive Dental Expense Benefit

The Comprehensive Dental Expense Benefit provides coverage for a wide range of services called Covered Expenses. The services associated with this benefit are covered to the extent that they are:

1. Medically Necessary;
2. Prescribed by or given by a Dentist or Physician; and
3. Provided for care and treatment of a Covered Illness or Injury;

Benefits are payable in accordance with the applicable deductible amounts and benefits percentages listed in the Plan Payment Provisions.

Dental Schedule of Benefits

Calendar Year Deductible

There is NO Calendar Year Deductible for This Plan.

Calendar Year Maximum Per Person

The Calendar Year Maximum Benefit under This Plan is $1,000 per Covered Person.

Coinsurance

The Coinsurance for This Plan, per Calendar Year, is as follows:
100% of the first $100
80% of the next $300
50% of the next $1,320

Five Year Rule

Charges for replacing an appliance or prosthetic device, such as a denture, crown or bridge, will not be covered, unless it is at least five (5) years old or cannot be made usable.

Teeth Lost Before Covered Under This Plan

There are no benefits for a prosthetic device which replaces teeth lost before becoming Covered under This Plan, unless the device also replaces one or more natural teeth lost or extracted after the Covered Person became Covered under This Plan.

Waiting Period for Late Enrollees

Type A:	Preventive Services	No restriction
Type B:	Basic Services	Six (6) month waiting period
Type C:	Major Services	Twelve (12) month waiting period

Plan Payment Provisions

The following is a complete list of Covered Dental Procedures under this Dental Expense Benefit. Any procedure not listed is excluded.

Type A: Preventative Services

There is no Late Enrollee restriction for Preventative Services.

The Deductible is waived for all Preventative Services.

1. Prophylaxis and fluoride treatments, including:
    a. Examination, scaling and polishing;
    b. Topical application of fluoride; and
    c. Application of Sealant (Limited to Children under age 14).
2. Space Maintainers (limited to the initial appliance only and for children under age 16 only) including:
    a. All adjustments in the first six (6) months after installation;
    b. Fixed, unilateral, bond or stainless steel crown type;
    c. Fixed, unilateral, cast type; or
    d. Removable, bilateral type.
3. Fixed and removable appliances to inhibit thumb sucking and other harmful habits (limited to Covered Persons under age sixteen (16), and limited to the appliance only) including all adjustments in the first six (6) months after installation.
4. Diagnostic Services including:
    a. Examination and Diagnosis;
    b. X-rays:
        i. Full mouth series of at least fourteen (14) films including bitewings, if needed;
        ii. Bitewing films;
        iii. Other intraoral periapical or occlusal films, single films; iv. Extraoral superior or inferior maxillary film;
        v. Panoramic film, maxilla and mandible;
        vi. Initial or periodic oral examination;
        vii. Emergency palliative treatment and other non-routine unscheduled visits.
5. Emergency Treatment including Outpatient treatment of Injuries resulting from an accident.

Type B: Basic Services

No Basic Services will be covered under this Plan for the first six (6) months of Coverage for all Late Enrollees.

1. Office visits and examinations (for Diagnostic consultation with a Dentist other than the one providing treatment, payment is only made if no other service is rendered during the visit).
2. Diagnostic services including:
    a. Examination and diagnosis;
    b. Diagnostic casts; and

c. Biopsy and examination of oral tissue.

3. Restorative services (multiple restorations on one surface will be considered one restoration) including:
    a. Amalgam restorations;
    b. Synthetic restorations:
        i. Silicate cement;
        ii. Acrylic or plastic;
        iii. Composite resin;
    c. Re-cementing of Crowns:
4. Oral surgery including routine X-rays, the treatment plan, local anesthetics and postsurgical care for:
    a. Extractions:
        i. Uncomplicated extraction, one or more teeth;
        ii. Surgical removal of erupted teeth, involving tissue flap and bone removal;
        iii. Surgical removal of impacted teeth;
    b. Other surgical procedures:
        i. Alveolectomy, per quadrant;
        ii. Stomatoplasty with ridge extension, per arch;
        iii. Excision of pericoronal gingiva, per tooth; iv. Removal of palatal torus;
        v. Removal of mandibular tori, per quadrant;
        vi. Excision of hyperplastic tissue, per arch;
        vii. Removal of cyst or tumor;
        viii. Incision and drainage of abscess;
        ix. Closure of oral fistula of maxillary sinus;
        x. Reimplantation of tooth;
        xi. Frenectomy;
        xii. Suture of soft tissue Injury;
        xiii. Sialolithotomy for removal of salivary calculus; xiv. Closure of salivary fistula;
        xv. Dilation of salivary duct;
        xvi. Sequestrectomy for osteomyelitis or bone abscess, superficial;
        xvii. Maxillary sinusotomy for removal of tooth fragment or foreign body.
5. Denture Services including:
    a. Denture repairs, acrylic - repairing dentures, no teeth damaged;
    b. Denture repairs, metal;
    c. Denture reline:
        i. Office reline, cold cure;

ii. Laboratory reline;

d. Denture adjustments;

Excluding Specialized techniques and characterization.

6. Other services:
    a. General anesthesia in conjunction with surgical procedures only;
    b. Injectable antibiotics needed solely for treatment of a dental condition.

Type C: Major Services

No Major Services will be covered under This Plan for the first twelve (12) months of Coverage for all Late Enrollees.

1. Prosthodontic services:
    a. Dentures and all adjustments performed by the Dentist furnishing the dentures:
        i. Full dentures, upper or lower;
        ii. Partial dentures including base, all clasps, rests, teeth and:
            1. Upper, with two (2) chrome clasps with rests, acrylic base;
            2. Upper, with chrome palatal bar and clasps, acrylic base;
            3. Lower, with two (2) chrome clasps with rests, acrylic base;
            4. Lower, with chrome lingual bar and clasps, acrylic base;
            5. Stayplate base, upper or lower (anterior teeth only); iii. Adding teeth to partial dentures to replace extracted natural teeth; iv. Denture repairs, acrylic:
            1. Repairing dentures and replacing one or more broken teeth;
            2. Replacing one or more broken teeth, no other damage;
        v. Denture duplication, jump case;
        vi. Tissue conditioning.
    b. Fixed bridges (each abutment and each pontic makes up a unit in a bridge):
        i. Bridge abutments (see inlays and crowns under);
        ii. Bridge pontics:
            1. Cast metal, sanitary;
            2. Plastic or porcelain with metal;
            3. Slotted facing;
            4. Slotted pontic; iii. Simple stress breakers, per unit;
        iv. Removable bridges, unilateral partial, one piece chrome casting, clasp attachment, including pontics.

    Excluding charges for Specialized techniques and characterizations.
2. Crowns:
    a. Temporary crowns;

b. Stainless crowns;
c. Pins – pin retention, exclusive of restorative material;
d. Crowns and posts (only Covered when needed because of decay or injury, and only when the tooth cannot be restored with a routine filling material):
    i. Acrylic with metal;
    ii. Porcelain;
    iii. Porcelain with metal; iv. Full cast metal (other than stainless steel);
    v. 3/4 cast metal (other than stainless steel);
    vi. Cast post and core, in addition to crown (not a thimble coping);
    vii. Steel post and composite or amalgam core, in addition to crown;
    viii. Cast dowel pin (one-piece with crown).

3. Endodontic services including:
    a. Pulp capping direct;
    b. Remineralization (calcium hydroxide), as a separate procedure;
    c. Vital pulpotomy;
    d. Apexification;
    e. Root canal therapy of non-vital (nerve dead) teeth:
        i. Traditional therapy;
        ii. Medicated paste therapy, N2 Sargenti;
    f. Apicoectomy, as a separate procedure or in conjunction with other Endodontic procedures.
4. Periodontic services including Treatment plan, Local anesthetics, and Post-surgical care for the following:
    a. Gingivectomy or ginivoplasty, per quadrant;
    b. Gingivectomy per tooth (fewer than six teeth);
    c. Subgingival curettage and root planning, per quadrant;
    d. Pedicle or free soft tissue grafts, including donor sites;
    e. Osseous surgery, including flap entry, closure per quadrant;
    f. Osseous surgery, including flap entry, closure and donor sites;
    g. Muco-gingival surgery;
    h. Occlusal adjustment not involving restorations and done in conjunction with periodontic surgery, per quadrant;
    i. Inlays;
    j. Onlays, in addition to inlays.

Type D: Orthodontic Services

This is NOT a Covered Expense under This Plan.

Orthodontic Benefits include the following:

1. Any of the Covered Dental Expenses in This Plan in connection with Orthodontic treatment, including the movement of one or more teeth by the use of active appliances. It also includes:
    a. Diagnostic Services;
    b. The Treatment Plan;
    c. The fitting, making, and placement of an active appliance; and
    d. All related office visits, including post-treatment stabilization.
2. Surgical exposure of impacted or erupted teeth in connection with orthodontic treatment including:
    a. Routine X-rays;
    b. Local anesthetics; and
    c. Post-surgical care.

See also *Orthodontic Benefit – Lifetime Maximum*

Alternative Treatment

In all cases in which there are optional treatments available which produce a professionally satisfactory result, only the least costly alternative will be considered eligible under This Plan.

Anesthesia Services

Anesthetics and their professional administration when ordered by the Attending Physician or Dentist in connection with a Covered Procedure.

Assault or Illegal Occupation

This is NOT a Covered Expense under This Plan.

Charges related to treatment received as a result of and while committing or attempting to commit an assault or felony, or injuries sustained while engaged in an illegal occupation.

Calendar Year Deductible

The Calendar Year Deductible is satisfied using Covered Expenses incurred within the Calendar Year. The Calendar Year Deductible must be satisfied before the applicable Coinsurance will be applied.

When three (3) Covered Participants have each satisfied a Deductible during one Calendar Year, the Family Deductible will be considered satisfied for the remainder of that Calendar Year.

Calendar Year Maximum Per Person

The total amount payable for covered dental services (not including Orthodontic Benefit) incurred by a Covered Person during the Calendar Year.

Coinsurance

The Coinsurance for This Plan, per Calendar Year, is as follows:
100% of the next $100 80%
of the next $300
50% of the next $1,320

Coinsurance is the percent of a Covered Expense that The Plan pays after satisfaction of any applicable Deductible.

Cosmetic Expenses

This Plan requires pre-approval on all cosmetic expenses. Procedures or services are only covered to the extent that they result in the improvement of a bodily function and are Medically Necessary.

Date Charges are Incurred

Covered charges for Dental Expenses will be considered to be incurred as follows:

1. For a prosthetic device, on the date the master impression is made;
2. For a crown, a bridge or cast restoration, on the date the tooth or teeth are prepared;
3. For root canal treatment, on the date the pulp chamber is opened;
4. For Orthodontic treatment, on the date the active appliance is first placed;
5. For all other charges, on the date service is rendered or a supply is furnished.

Deductible

See *Calendar Year Deductible*.

Dentist Charges, Certain

This is NOT a Covered Expense under This Plan.
Charges for telephone consultations, failure to keep scheduled appointments, completion of claim forms or providing dental information necessary to determine coverage.

Employment Related Injury or Illness

This is NOT a Covered Expense under This Plan.
Charges for or in connection with an Injury or Illness which arise out of or in the course of any employment for wage or profit, or for which the individual is entitled to benefits under Workers' Compensation Law, Occupational Disease Law or similar legislation.

Excess of the Benefits Specified in This Plan

Charges not covered, or charges for Benefits not covered under This Plan.

Experimental or Investigational Services or Supplies

This is NOT a Covered Expense under This Plan.

Charges incurred for services, supplies, devices, treatments, procedures and drugs which are not reasonable and necessary or that are investigational or experimental for the diagnosis or treatment of any Illness, disease, or Injury for which any of such items are prescribed.

Experimental services are further defined as those services which:

1. Are not accepted as standard medical treatment for the Illness, disease or Injury being treated by a Physician's suitable medical specialty;
2. Are the subject of scientific or medical research of study to determine the item's effectiveness and safety;
3. Have not been granted, at the time services were rendered, and required approval by a federal or state governmental agency, including without limitation, the Federal Department of Health and Human Services, Food and Drug Administration, or any comparable state governmental agency, and the Federal Health Care Finance Administration as approved for reimbursement under Medicare Title XVIII; or
4. Are performed subject to the Covered Person's informed consent under a treatment protocol that explains the treatment or procedure as being conducted under a human subject study or experiment.

Family Provided Services

This is NOT a Covered Expense under This Plan.

Charges for services or supplies rendered by the Employee, Employee's Spouse, or the Children, Brothers, Sisters, Parents, or Grandparents of either the Employee or the Employee's Spouse.

Five Year Rule

Charges for replacing an appliance or prosthetic device, such as a denture, crown or bridge, will not be covered, unless it is at least five (5) years or and cannot be made usable.

Foreign Assignments

When temporarily assigned outside the United States of America, Medically Necessary Charges and Services, rendered by a licensed Physician or facility, incurred in a foreign country will be covered the same as if they had been incurred within the United States subject to all other provisions of This Plan.

Foreign Travel

When travel outside the United States was for the sole purpose of obtaining medical treatment, Charges and Services received are not Covered Expenses under This Plan.

When temporarily traveling outside the United States of America, Medically Necessary Charges and Services, rendered by a licensed Physician or facility, incurred in a foreign country will be covered the same as if they had been incurred within the United States subject to all other provisions of This Plan.

Government Owned / Operated Facility

This is NOT a Covered Expense under This Plan.

Charges by a facility owned or operated by the U.S. Federal, State or Local government, unless the individual is legally obligated to pay. This does not apply to covered expenses rendered by a hospital owned or operated by the U.S. Veteran's Administration when the services are provided for a non-service related Illness or Injury.

Incapacitated Child Provision

The child must be:

1. Incapable of self-sustaining employment because of intellectual disability or physical handicap that existed before the child reached the limiting age; and
2. Be chiefly dependent on the employee for support; and 3. Charges are not a covered expense under a conversion policy.

To qualify for continued coverage under the Incapacitated Child provision, the child must meet specific requirements as defined in This Plan.

Late Enrollment Restriction

See the specific coverage for limitations.

If the Employee or Dependent is not enrolled for Dental Coverage within thirty-one (31) days of eligibility, certain coverages may be limited.

No Legal Obligation to Pay

This is NOT a Covered Expense under This Plan.

Charges by a physician, facility or other provider in which the individual is not legally obligated to pay.

Not Medically Necessary

This is not a Covered Expense under This Plan.

Treatment of an Injury or Illness which is not Medically Necessary. This includes charges for care, supplies or equipment.

Personal Hygiene

This is not a Covered Expense under This Plan.

Items for personal hygiene and convenience which are Not Medically Necessary, such as, but not limited to, air conditioners, bathing / toilet accessories, and physical fitness equipment.

Teeth Lost Before Covered Under This Plan

There are no benefits for a prosthetic device which replaces teeth lost before becoming Covered under This Plan, unless the device also replaces one or more natural teeth lost or extracted after the Covered Person became Covered under This Plan.

War or acts of War

This is not a covered Expense under This Plan.

Declared or undeclared, including an Injury sustained or Illness contracted while on duty with any Military Service for any country.

General Limitations and Exclusions – Dental

No payment will be made under any portion of This Plan for expenses incurred by a Covered Person for:

Charges to the extent that the Covered Person is reimbursed, entitled to reimbursement, or in any way indemnified for those expenses by or through any public program;

Charges which would not customarily have been made if no coverage had existed, except where prohibited by law);

Charges for services and supplies which are furnished without the recommendation of a Physician for the care and treatment of an Illness or Injury, including court ordered or directed care or evaluation;

Charges for any services rendered outside the scope of the license of the institution or practitioner providing the service;

Charges which are in excess of Reasonable and Customary Charges (when no Network is in place or services are rendered Out-of-Network);

Charges which are not Medically Necessary, or reasonably necessary to the care and treatment of an Illness or Injury;

Charges for benefits other than specifically provided or in excess of the benefits specified in This Plan;

Charges which are Experimental, Investigational, or for research, or charges for services and supplies which are not in accordance with generally accepted professional medical standards or with the generally accepted methods of treatment;

Charges for Hospital confinement commencing or services and supplies provided before the Effective Date of Coverage under This Plan, or provided after the Termination of Coverage under This Plan (except as otherwise specified);

Charges for travel, whether or not recommended by a Physician (see the Ambulance Service benefit for additional details);

Charges as a result of Hospital inpatient admission primarily for diagnostic or medical examination for which necessary care or treatment could properly be performed on an outpatient basis without adversely affecting the health of the patient;

Charges outside of the 12 month filing limit of the Plan;

Charges incurred for fluoride other than for services performed in the Dentist's office as described under Preventative Services.

EXCLUSIONS:

Except as specifically stated, no benefits will be payable under this Plan for:

1. **Analgesia** – Separate charges for pre-medication, local anesthesia, analgesia, or conscious sedation.
2. **Appliances** – Items intended for sport use, such as athletic mouth guards.
3. **Congenital or Development Conditions** – The treatment of congenital (hereditary) or developmental (following birth) malformations.
4. **Crowns** – Crowns placed for the purpose of periodontal splinting.
5. **Customized Prosthetics** – Precision or semi-precision attachments, overdentures, or customized prosthetics.
6. **Discoloration Treatment** – Any treatment to remove or lessen discoloration except in connection with endodontia.
8. **Excess Care** – Services, which exceed that necessary to achieve acceptable level of dental care. If the Plan Administrator determines that alternative treatment could be (could have been) provided for the least costly procedure (s) which would produce a professionally satisfactory result.
9. **Duplicate prosthetic devices or appliances** – Temporary partials, temporary bridgework and temporary dentures.
10. **Excess Charges** – Charges in excess of the Usual, Customary and Reasonable charge for dental services or supplies.
11. **Experimental Procedures** – Services which are considered experimental or which are not approved by the American Dental Association.
12. **Grafting** – Extra oral grafts (grafting of tissue from outside the mouth to oral tissues).

13. **Implants** – Implants (materials implanted into or on bone or soft tissue) or the removal of implants.
14. **Lost or Stolen Prosthetics or Appliances** – Replacement of a prosthetic or any other type of appliance which has been lost, misplaced, or stolen.
15. **Medical Plan Coverage** – Any dental services to the extent to which coverage is provided under the terms of the medical benefits sections of this Plan.
16. **Myofunctional Therapy** – Muscle training therapy or train to correct or control harmful habits.
17. **Non-Professional Care** – Services rendered by other than a dentist (D.D.S or D.M.D) or a dental hygienist or x-ray technician under the supervision of a dentist.
18. **Occlusal Restoration** – Procedures, appliances or restorations that are performed to alter, restore or maintain occlusion (i.e., the way the teeth mesh) or change vertical dimension, except as outlined in Type D.
19. **Oral Hygiene Counseling** – Education or training in and supplies used for dietary or nutritional counseling, personal oral hygiene instruction or plaque control. Charges for supplies normally used at home, including but not limited to toothpaste, toothbrushes, water-piks, and mouthwashes.
20. **Orthognathic surgery.**
21. **Personalization or Characterization of Dentures.**
22. **Prescription Drugs** – Prescription drug coverage is provided only under the terms of the Medical portion of this Plan, if any.
23. **Prior to Effective Date** – Charges for courses of treatment which were begun prior to the Covered Person's effective date, including crowns, bridges or dentures which were ordered prior to the effective date.
24. **Prosthetics** – Initial placement of a prosthetic (i.e., a bridge, partial or full denture, including crowns or inlays used as abutments) for teeth extracted/lost prior to the effective date of coverage under this Plan or the prior plan of the Employer. Replacements will only be covered if the original is at least five years old and no longer serviceable or damaged in an accident while covered.
25. **Addition of teeth to partial dentures or fixed bridgework**, except for the replacement of teeth which are extracted while the person is covered under the Plan. Also, adjustment of prosthetic appliances within six (6) months of initial installation and not included in the cost of such appliance.
26. **Sealants** – Materials applied to the teeth to seal developmental imperfections, such as pits and fissures. (Covered up to age fourteen (14).)
27. **Service or Supply** not shown on the Schedule of Covered Procedures.
28. **Splinting** – Wiring or bonding teeth or crowns to act as a splint for any reason.
29. **Treatment of malignancies and neoplasm's.**
30. **Temporomandibular Joint Dysfunction / Maxillofacial Surgery** – Any charges for jaw (mandibular) augmentation or reduction procedures; or procedures, restorations or appliances for the treatment or for the prevention of Temporomandibular Joint

Dysfunction Syndrome, including the correction of abnormal positioning and relationship of teeth. **(See also Medical Plan section)**

NOTE:
No benefits will be payable for a prosthetic where the impression(s) was taken during the last thirty (30) days of eligibility. In addition, no benefits will be payable for s that are placed after the termination date of coverage, regardless of when the impression was taken.

Eligibility and Effective Date of Coverage

Employee Eligibility

The following employees will be eligible to be covered under This Plan:

A full-time employee of the Employer who is in Active Service on or subsequent to the effective date of This Plan and who has completed any waiting period specified by the Employer; excluding in any case part-time employees, temporary employees, retirees, and employees who work fewer than thirty (30) hours per week. If an employee is an individual only while they are actively engaged in and devoting substantial time to the business of the Participating Employer.

If an employee qualifies both as an Employee and a Dependent, such person may only be covered as one of the above and not both an Employee and a Dependent.

Effective Date of Employee Coverage

Coverage will become effective for an Employee as indicated below, provided the Employee is in Active Service on that date; otherwise, the effective date will be deferred until the date following a return to Active Service.

Coverage for an Employee whose employment commenced on or before the Plan effective date and who was validly covered by a plan provided by the Employer which was replaced by This Plan, will become effective on the Plan effective date, if on that date the waiting period, as specified in the SUMMARY PLAN DESCRIPTION section, has been satisfied.

Coverage for any other Employee will become effective on the first of the month following satisfaction of the waiting period, as specified in the SUMMARY PLAN DESCRIPTION.

Each Employee will be covered on the above effective date provided enrollment and any required contributions have been made within thirty-one (31) days after the date of eligibility. If enrollment is made more than thirty-one (31) days after the date of eligibility, either by way

of a Special Enrollment Period or during the Annual Open Enrollment, the insured will be subject to an eighteen (18) month pre-existing period if age nineteen (19) or older..

Dependent Eligibility

The following persons shall be eligible to be covered as Dependents under This Plan:

1. The lawful spouse of the Employee. The term spouse shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator my require documentation proving a legal marital relationship.
2. An Employee's child from the date of birth to age twenty-six (26) regardless of the child's financial dependency, residency, student, employment and/or marital status.
    a. The Plan may EXCLUDE an adult child who has not attained age twenty-six (26) if the child is eligible to enroll in an eligible employer-sponsored health plan other than a parent's group health plan.
    b. The Plan is NOT required to extend coverage to any child or spouse of a covered dependent child.

An intellectually disabled or physically handicapped child may continue coverage beyond the limiting age. For further details, please refer to Incapacitated Child and to the EXTENDED COVERAGE FOR DEPENDENT CHILDREN sections.

The term "child" includes the following subject to the age limits and requirements specified above:

1. The Employee's natural child;
2. A legally adopted child from the date the Employee assumes legal responsibility; 3. A stepchild; or
4. A legal foster child, provided that one or both of the child's natural parents does not reside with the Employee as well. In addition, the foster child is not considered a Dependent if the welfare agency provides all or part of the child's support.
5. A child or children of which the covered Employee has been designated the Legal Guardian.

The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights. At any time, the Plan may require proof that a Spouse or child qualifies or continues to qualify as a Dependent as defined by the Plan.

All other persons are excluded.

If both parents of any Dependent Child are Covered Employees, then for the purposes of This Plan, the Dependent Child can be Dependent of one parent only.

An employee will be eligible to enroll for dependent coverage on whichever of the following dates is first to occur:

1. The date the Employee is eligible for coverage, if on that date the employee has such Dependents;
2. The date the Employee first gains a Dependent (see EFFECTIVE DATE OF COVERAGE FOR NEWBORN CHILDREN section for details on newborns).

Effective Date of Dependent Coverage

Coverage will become effective for a Dependent, other than a Newborn Child, as indicated below, provided both the Employee and Dependent are in Active Service on that date and the Dependent is not confined in a Hospital, other institution or home on that date; otherwise, the effective date will be deferred until the day following a return to Active Service. A Dependent's effective date will be determined as follows:

1. The date on which the Employee becomes covered if there are any Dependents on that date;
2. If the Employee is without a Dependent on the date the Employee becomes covered, Dependent coverage will become effective on the date a Dependent is acquired provided enrollment for coverage is made within thirty-one (31) days after the Dependent is acquired and any required contribution is paid within thirty-one (31) days after the Dependent is acquired.
3. If the Employee has Dependent coverage, coverage for any newly acquired Dependents (see EFFECTIVE DATE OF COVERAGE FOR NEWBORN CHILDREN section for details on Newborns) will be effective on the date the Dependent is acquired provided that enrollment is made within thirty-one (31) days of the date that the Dependent is acquired and any required contribution is paid within thirty-one (31) days after the Dependent is acquired. This will be allowed under the Special Enrollment Period.
4. Each Dependent will be covered on the above Effective Date provided enrollment and any required contributions have been made within thirty-one (31) days after the date of eligibility. If enrollment is made more than thirty-one (31) days after the date of eligibility, either by way of a Special Enrollment Period or during the Annual Open Enrollment, the insured will be subject to an eighteen (18) month pre-existing period if age nineteen (19) or older.

Effective Date of Coverage for Newborn Children

A Newborn Child will automatically become Covered from birth (as long as an enrollment card is completed) if Dependent Coverage is in force at the time of birth. The Employee may be required to make an additional contribution if needed for the Newborn within thirty-one (31) days after the date of birth depending on previous benefit selections. Coverage will be provided to the same extent as for other Covered Dependent children. If at the time of birth

the Covered Employee is acquiring the first Dependent, the Employee must enroll for Dependent Coverage within thirty-one (31) days after the date of birth.

The Employee must make an additional contribution for the Newborn from the date of birth if required by This Plan. If this is done, Dependent Coverage will become effective as of the date of birth under the Special Enrollment Period provision.

If a Newborn Child is not enrolled within thirty-one (31) days after the date of birth, the Newborn may not be enrolled until the following Annual Open Enrollment period unless there is another Change in Family Status prior to the Annual Open Enrollment period.

Change in Classification of a Covered Employee

Any change in the amount of an employee's coverage resulting from a change in the employee's classification shall become effective on the first of the month coincident with or next following the date the change occurs, provided the employee is in Active Service on that date; otherwise the effective date of the change shall be the first day on which the employee is in Active Service.

Change in classification by reason of attainment of a specified age shall be effective on the first of the month during which the employee attains the limiting age.

Change in Classification of a Covered Dependent

Any change in the amount of an dependent's coverage resulting from a change in the employee's classification shall become effective on the first of the month coincident with or next following the date the change occurs, except that if on that date the dependent is not in Active Service, the change shall not become effective until such dependent returns to Active Service.

Any change in the amount of a dependent's coverage as a result of a change in the dependent status, shall automatically become effective on the date such change in dependent status becomes effective.

Qualified Medical Child Support Order (QMCSO)

QMCSO's obligate a noncustodial parent by a child support order to provide medical support for his or her children. QMCSO's require group health plans to provide benefits to a child of a participant.[2]

Effect of Prior Coverage

This Plan will not provide benefits to employees or dependents who are Totally Disabled on the date of discontinuance of the preceding plan and entitled to any extension of benefits provision.

Special consideration will be given to covered medical expenses incurred by an employee or dependent covered under the Employer's or Participating Employer's preceding group plan up to the effective date of This Plan. Those covered expenses applied to the prior plan's Calendar Year deductible amount and coinsurance limit (if any) will be applied to the respective provisions in This Plan for the same Calendar Year deductible amount and coinsurance limit upon submission of proof of consideration by the prior plan.

Termination Date of Coverage

Termination of Employee Coverage

A covered Employee's coverage will terminate immediately upon termination of This Plan or on the date indicated in the GENERAL INFORMATION section, after the occurrence of the first of the following events:

1. If the Covered Employee fails to remit required contributions for coverage when due, coverage will terminate at the end of the period for which a contribution is made;
2. Termination of the Active Service, except as specified below and in the COVERAGE AFTER TERMINATION section;
3. When the Covered Employee enters the military, naval or air force of any country of international organization of a full-time active duty basis other than scheduled drills or other training not exceeding one month in any Calendar Year;
4. When the Covered Employee ceases to maintain full-time residency in the United States of America or Canada, unless employer assigned outside the U.S. or Canada; or
5. When the Covered Employee ceases to be in a class eligible for coverage.

Family and Medical Leave Act of 1993 (FMLA)

If a Covered Employee ceases Active Service due to an approved Family Medical Leave of Absence in accordance with all policies and procedures in effect governing such Leave, health coverage will be continued under the same terms and conditions which would have been provided had the Covered Employee continued in Active Service, for a period of time not to exceed twelve (12) weeks, provided the Employee continues to pay any premiums normally required for Coverage, either by prepayment or at the same time as payments would have been due.

Said premiums will remain at the same level as on the date immediately prior to the Leave, unless This Plan experiences a premium change for its entire Plan.

If the Covered Employee does not return to Active Service after the approved Family Medical Leave or if the Employee has given the Employer notice of intent not to return to Active Service during the Leave Period, coverage may be continued under the CONTINUATION OF COVERAGE (COBRA) provision of This Plan, provided Coverage has not lapsed, effective with the date notification is given by the Employee to the Employer, and provided the Covered Employee elects to continue such Coverage under that provision. The time period that Coverage was continued during the Family Medical Leave will not be counted toward the maximum time that coverage can be continued under COBRA.

If the Employee fails to make the required premium contribution for coverage to continue during the Leave within thirty (30) days after the date the premium was due, coverage may be continued under the COBRA provisions of This Plan as of the date the Coverage lapsed. COBRA continuation of coverage must be elected during this time in order for coverage to be continued. If Coverage under This Plan is terminated during an approved Family Medical Leave due to non-payment of required premiums by the Employee, and the Employee returns to Active Service immediately upon completion of the Leave Period, Coverage will be reinstated on the date the Employee returns to Active Service without having to satisfy any waiting period or the Pre-existing Condition provision of This Plan provided the Employee makes any necessary premium contributions and re-enrolls for Coverage within thirty-one (31) days of the return to Active Service.

Approved Leaves of Absence[3] are:

1. For the birth of the employee's child and to care for the newborn child;
2. For placement with the employee of a son or daughter for adoption or foster care;
3. To care for the employee's spouse, son, daughter or parent with a serious health condition; or
4. For a serious health condition that makes the employee unable to perform the functions of the job.
5. For qualifying exigencies arising out of the fact that the employee’s spouse, son, daughter, or parent is on active duty or call to active duty status as a member of the National Guard or Reserves in support of a contingency operation;
6. For a serious injury or illness of the employee’s spouse, son, daughter, parent or next of kin of a covered servicemember.

An employee is eligible for FMLA leave if he or she has at least twelve (12) months of service with the Employer and if he or she has worked at least 1,250 hours during the 12-month period preceding the start of the leave.

<u>Core Management Resources Leave of Absence Policy</u>

- Requests for unpaid leave of absence should be submitted to management with as much notice as possible.
- Any available vacation and sick time must be exhausted first.

- To retain your health insurance coverage while on a leave of absence, you will be responsible for paying the full cost of your health insurance at the group rate.

Termination of Dependent Coverage

A Covered Dependent's coverage will terminate immediately upon termination of This Plan or on the date indicated in the GENERAL INFORMATION section, after the occurrence of the first of the following events:

1. When the Covered Employee is terminated for any reason including death;
2. When the Covered Employee ceases to make the required contributions for the dependent;
3. When the Covered Employee ceases to be in a class of employees eligible for dependent coverage;
4. When any Dependent ceases to meet the requirements of an Eligible Dependent, except as specified below and in the COVERAGE AFTER TERMINATION provision;
5. When such Dependent enters the military, naval or air force of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding one month in any Calendar Year;
6. When such Dependent becomes a Covered Employee;
7. When such dependent ceases to maintain full-time residency in the United States of America or Canada, unless employer assigned outside the U.S. or Canada; or
8. When dependent coverage is discontinued under This Plan.

Extended Coverage for Dependent Children

A child age twenty-six (26) and older who is physically handicapped or intellectually disabled may qualify for coverage beyond the age when other dependent coverage would end as long as ALL the following requirements are met:

1. The child is severely disabled by prolonged physical or mental incapacity;
2. The child became disabled prior to reaching age twenty-six (26);
3. The child was covered by The Plan prior to reaching age twenty-six (26), or, if older than age twenty-six (26), loses coverage under a parent’s plan. In the event of loss of coverage, proof of coverage must be provided;
4. The child is unmarried and the Covered Employee provides more than 50% of his or her support because he or she is unable to earn a living due to intellectual disability or physical handicap.

For the dependent child to qualify, notice must be given to the Third Party Administrator within thirty-one (31) days after the date dependent coverage would normally end.

The extension of coverage will continue as long as the incapacity continues, the Covered Employee maintains dependent coverage, and This Plan remains in full force and effect. Proof of handicap may be required periodically.

Children who become disabled after age twenty-six (26) are not eligible for coverage.

Coverage After Termination

Continuation of Coverage – Consolidated Omnibus Budget Reconciliation Act (COBRA) (Plans with 20 or more employees)

A Covered Person whose coverage has been terminated for any qualifying event enumerated below has the right to continue coverage for all benefits of This Plan if covered for such benefits on the day immediately preceding the termination date. The time period for which the continuation is available is indicated on the following pages in conjunction with the corresponding qualifying event.

If Continuation of Coverage is elected, coverage will continue as though termination of employment or loss of eligible status had not occurred. Any accumulation of deductibles or benefits paid prior to termination or loss of eligibility, which had been credited toward any deductible or maximum benefit of This Plan will be retained.

Also, no new or additional waiting period, pre-existing condition limitations or evidence of good health requirements will apply. If any changes are made to the coverage for employees in Active Service, the coverage provided to individuals under this continuation provision will be similarly modified.

Qualifying Events

An EIGHTEEN (18) MONTH continuation is available to Covered Employees and/or Covered Dependents if any one of the following qualifying events occurs:

1. A Covered Employee's termination of employment for any reason except gross misconduct; or
2. A Covered Employee's loss of eligibility to participate due to reduced work hours.

A TWENTY-NINE (29) MONTH continuation shall be available to all qualified beneficiaries if a Covered Person is disabled, per a determination under the Social Security Act, within sixty (60) days of the Covered Employee's termination of employment or reduction in work hours.

The Covered Person must provide the Plan Sponsor with notice of the disability within sixty (60) days of the determination of the disability by Social Security and before the end of the original eighteen (18) month COBRA coverage period. The Covered Person must notify the Plan

Sponsor of a determination by Social Security that the individual is no longer disabled within thirty (30) days of such determination.

A THIRTY-SIX (36) MONTH continuation shall be available to a Covered Dependent spouse and/or child if any one of the following qualifying events occurs:

1. A Covered Employee's death;
2. Divorce or legal separation from a Covered Employee;
3. A Covered Dependent child's loss of eligibility to participate due to age; or
4. A Covered Dependent's loss of eligibility to participate in This Plan due to the Covered Employee becoming covered by Medicare as a result of Total Disability or choosing Medicare in place of This Plan at age sixty-five (65).

If any employee becomes covered by Medicare, but no loss of coverage results for the employee or the Covered Dependents, and a subsequent qualifying event occurs, the duration of coverage for all qualified beneficiaries other than the Covered Employee must be at least thirty-six (36) months from the date on which the employee became covered by Medicare.

Notice of Continuation

A Covered Person has at least sixty (60) days form the date of loss of coverage as a result of a qualifying event or sixty (60) days from the date the Plan Sponsor mails or otherwise provides the Covered Person with a notification of the Covered Person's rights pursuant to a qualifying event to elect coverage. Payment of initial premium is not required until the fortyfifth (45th) day after the election. All payments for coverage after the date of election are subject to a thirty (30) day grace period.

The Covered Person is required to notify the Plan Sponsor within sixty (60) days of any qualifying event of which it would not otherwise be aware, such as divorce, legal separation, or loss of dependent status by a dependent child.

The Covered Person is required to notify the Plan Sponsor with all information needed to meet its obligation of providing notice and continuing coverage.

Cost of Continuation

Contact the Employer for details regarding the cost of continuation.

Termination of Continuation of Coverage

Continuation of Coverage shall not be provided beyond whichever of the following dates is first to occur:

1. The date the maximum continuation period expires from the corresponding qualifying event;
2. The date This Plan is terminated;
3. The date the individual failed to make the required contribution to continue coverage;
4. The date the individual becomes covered under any other group health plan which does not contain any exclusion or limitation with respect to any pre-existing condition;
5. The date the individual becomes covered by Medicare (if the individual becomes covered by Medicare as a result of end stage renal disease, coverage will continue until the maximum continuation period expires for the corresponding qualifying event); or
6. In the month that begins more than thirty (30) days after a final determination has been made that an individual is no longer disabled.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. The rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

1. The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:
   a. The twenty-four (24) month period beginning on the date on which the absence begins; or
   b. The day after the date on which the person was required to apply for or return to a position
2. A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for thirty (30) days or less cannot be require to pay more than the Employee's share, if any, for the coverage.

3. An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed services.

In general, you must meet the same requirement for electing USSRRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

Instructions for Submission of Claims

Be sure the bills submitted include all of the following:

1. Employee's name, social security number and home address;
2. Patient's name, social security number and date of birth;
3. Employer's Name;
4. Name and address of the physician or Hospital
5. Physician's diagnosis;
6. Itemization of charges;
7. Date the injury occurred or illness began; and
8. Receipt for payment if reimbursement is to be made to the insured.

These items are REQUIRED in order to accurately pay claims. Certain claims may require additional information before being processed. Benefits payable under This Plan for any loss other than loss for which This Plan provides any periodic payment, will be paid immediately upon receipt of due written proof of such loss.

All payments will be issued directly to the provider of the service unless receipted bills showing payment has been made are submitted.

Please direct all claims and questions regarding claims to:

Core Administrative Services
PO Box 90
Macon, GA 31202-0090

478-741-3521
888-741-CORE (2673)

Every attempt will be made to help Covered Persons understand their benefits; however, any statement made by an employee of CAS or the Employer will be deemed a representation and not a warranty.

Actual benefit payment can only be determined at the time the claim is submitted and all facts are presented in writing. All benefit payments are governed by the provisions of the Summary Plan Description and Group Provisions pages.

If a definite answer to a specific question is required, please submit a written request, including all pertinent information and a statement from the attending Physician (if applicable), and a written reply will be sent, which will be kept on file.

Claim Provisions

Time Limit for Submitting Claims

Written proof of loss must be submitted within one (1) year of the date charges are incurred to be considered eligible for payment. Upon termination of Core Management Resources Group's agreement with the Third Party Administrator (claims payer), written proof of loss must be submitted within ninety (90) days of the date the termination occurred to be considered eligible for payment. A charge will be deemed incurred on the date services are actually rendered or supplies are actually received.

If it was not reasonably possible to submit the claim in the time required, the claim will not be reduced or denied solely for this reason, if the claim is submitted as soon as reasonably possible. To be accepted, the claim must be submitted no later than one (1) year from the date of loss unless the Covered Person was legally incapacitated.

Right to Investigate Claims

The Plan Sponsor acting on their behalf retains the right to request any medical information from any provider of service it deems necessary to properly process a claim.

A Physician designated by the Plan Sponsor will have the right and opportunity to examine, at its expense, any person whose Illness or Injury is the basis for any claim, when and as often as reasonably required and, in the event of death, to make an autopsy, unless prohibited by law.

Claim Denial

In the event a claim is denied, in whole or in part, the Covered Person will be given written notice of the following:

1. The reason for denial;
2. Specific reference to Plan provisions on which the denial was based;
3. Any additional material or information needed for further review of the claim; and
4. An explanation of the review procedure.

Appeal

If a claim is denied, in whole or in part, the Covered Person may appeal the denial by making a written request to the Plan Sponsor for review within sixty (60) days after the denial is received. A Covered Person has the right to:

1. Review the Summary Plan Description, Group Provision Pages, and other papers affecting the claim (except information which a Physician does not wish to be made known to the claimant);
2. Argue against the denial in writing; and
3. Have a representative act on behalf of the Covered Person in the appeal.

Review

The decision on review shall be in writing and shall be made within sixty (60) days of the receipt of the request for review. The Plan Sponsor will have the final authority to determine participant and benefit eligibility under the terms of the Plan (but not under any stop-loss insurance contract). If the claim is denied upon review, the decision must include the following:

1. The specific reason for denial;
2. The decision must be written in a manner understandable to the Covered Person; and
3. The written denial will contain specific reference to the pertinent Plan provision upon which the decision was based.

Legal Actions

No action at law or in equity shall be brought to recover on This Plan prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of This Plan. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

Coordination of Benefits

If a Covered Person is covered under more than one group plan, including This Plan and any other group medical benefits provided through or by the Employer, and one or more other plans, as defined below, the benefits will be coordinated. The benefits payable under This Plan for any Claim Determination Period, will be either its regular benefits or reduced benefits which when added to the benefits of the other plan, will equal no more than 100% of the Allowable Expenses, also defined below:

Coordination of Benefits Definitions

Allowable Expenses
Any Medically Necessary, Reasonable and Customary item of expense incurred by a Covered Person which is covered at least in part under This Plan.

Claim Determination Period
A Calendar or Plan Year or that portion of a Calendar or Plan Year during which the Covered Person for whom claim is made has been covered under This Plan.

Plan
Any plan under which medical or dental benefits or services are provided by:

1. Group, blanket or franchise insurance coverage;
2. Preferred Provider Organization (PPO);
3. Wholly or partially self-insured or self-funded group plans;
4. Group coverage under labor-management trusted plans, union welfare plans, Employer organization plans or employee benefit organization plans;
5. Coverage, including Medicare, under governmental programs or coverage required or provided by a statute, or provided by or required by statute, including no-fault auto insurance. (Refer to the EFFECT OF MEDICARE provision for treatment of this coverage under This Plan).

Health Maintenance Organization Coverage
This Plan will not consider as an Allowable Expense any charge which would have been covered by a Health Maintenance Organization (HMO) had a Covered Person for whom the HMO would be primary payer, used the services of an HMO Participating Provider. Nor, will This Plan consider any charge in excess of what an HMO provider has agreed to accept as payment in full.

Order of Benefit Determination
When a claim is made, the primary plan pays its benefits without regard to any other plans. The secondary plan adjusts its benefits so that the total benefits available will not exceed the

Allowable Expense. No plan pays more that it would without the Coordination of Benefits Provision.

A plan without a Coordination of Benefits provision is always the Primary Plan. If all plans have such a provision:

1. The Plan covering the person directly, rather than as an Employee's Dependent, is primary and the others are secondary;
2. Dependent Children of parents not separated or divorced:
    a. The Plan covering the parent whose birthday falls earlier in the year pays first. The Plan covering the parent whose birthday falls later in the year pays second;
    b. If both parents have the same birthday, the plan which covers the parent the longer period of time, pays first. However, if the other plan does not have this rule but instead has a rule based upon 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.
3. Dependent Children of separated or divorced parents: When parents are separated or divorced, their birthday rules do <u>not</u> apply. Instead:
    a. The plan of the parent with custody pays first;
    b. The plan of the spouse of the parent with custody (the step parent) pays next; and
    c. The plan of the parent without custody pays last.
    d. Unless the divorce decree specifies order of benefit determination, in which case, the order will be determined by the divorce decree.
4. Active/Inactive Employee: The plan covering a person as an employee who is neither laid off nor retired (or as that person's dependent) pays benefits first. The plan covering that person as a laid off or retired employee (or as that person's dependent) pays benefits second. If both plans do not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
5. If none of the above rules determines the order of benefits, the plan covering a person longer pays first. The plan covering that person for the shorter time period pays second.

Recovery

If the amount of the payment made by This Plan is more than it should have paid, the Plan has the right to recover the excess from one or more of the following:

1. The person This Plan has paid or for which it has paid; 2.
Insurance companies;
3. Other organizations.

Payment to Other Carriers

Whenever payments, which should have been made under This Plan in accordance with the above provisions, have been made under any other plan, This Plan will have the right exercisable alone and in its sole discretion to pay any organization making those payments any amounts it determines to be warranted in order to satisfy the intent of the above provisions. Amounts paid in this manner will be considered to be benefits paid under This Plan and, to the extent of these payments, This Plan will be fully discharged from liability.

Release of Information

For the purposes of determining the applicability of and implementing the terms of the above provisions of This Plan or any similar provision of another plan, the Third Party Administrator may, without the consent of or notice to any Covered Person, release to or obtain from, any information concerning any Covered Person, which is necessary for those purposes.

Any person receiving benefits under This Plan must furnish to the Third Party Administrator information about other coverage which may be involved in applying this Coordination of Benefits provision.

If This Plan contains a prescription benefit, NO Coordination of Benefits will apply for Prescription Drug Coverage.

Subrogation

Immediately upon payment of any benefits under This Plan, This Plan shall be subrogated to all rights of recovery against any person or organization whose course of conduct or action caused, or contributed to the loss for which payment was made under This Plan.

The Covered Person and persons, acting on his or her behalf, shall do nothing to prejudice The Plan's subrogation rights and shall, when requested, provide The Plan with accident related information and cooperate with The Plan in the enforcement of its subrogation rights.

The Covered Person acknowledges that This Plan's subrogation rights are a first priority claim against any potentially liable party to be paid before any other claim for the Covered Person's general damages, and This Plan shall be entitled to reimbursement even if the payments received by a Covered Person from a third party are insufficient to compensate a Covered Person in part or whole for all damages sustained.

For the purposes of this provision, a recovery which does not specify the matters covered shall be deemed to include a recovery for all expenses incurred to the extent of any actual loss due to the disability involved.

Rights of Recovery

In the event of any overpayment of benefits by This Plan, This Plan will have the right to recover the overpayment. If a Covered Person is paid a benefit greater than allowed in accordance with the provisions of This Plan, the Covered Person will be requested to refund the overpayment. If the refund is not received from the Covered Person, recovery procedures will be initiated. Similarly, if payment is made on the behalf of a Covered Person to a Hospital, Physician, or other provider of health care, and that payment is found to be an overpayment, the Plan will request a refund of the overpayment from the provider.

ERISA Rights of Covered Employees

As a participant in This Plan, Covered Persons are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) as amended. ERISA provides that all Plan participants shall be entitled to:

1. Examine, without charge, at the Plan Sponsor's office and at other specified locations, such as worksites or union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.
2. Obtain, upon written request to the Plan Sponsor, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Sponsor may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report (if applicable). The Plan Sponsor is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of This Plan. The people who operate This Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a Federal Court. In such a case, the court may require the Plan Sponsor to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Sponsor.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay the court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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

Termination of The Plan

The Employer shall have the right, at any time, to terminate or amend This Plan. The Employer makes no promise to continue these benefits in the future and the right to future benefits will never vest. Upon termination, the rights of the Covered Persons to benefits are limited to claims incurred and due up to the date of termination.

Definitions

The following are definitions of the terms which appear in the booklet:

Accidental Injury

Bodily Injury sustained by a Covered Person as the result of an unforeseen event and which is the direct cause (independent of disease, bodily infirmity, or any other cause) for care which the Covered Person receives.

Active Service

A Covered Employee will be considered in Active Service:

1. On a day which is a scheduled work day if the Covered Employee is:
    a. Performing in the customary manner all of the regular duties of the occupation on a full-time basis either at the customary place of employment or at some location to which travel is required; or
    b. Absent solely by reason of vacation; or
2. On a day which is not a scheduled work day only if the Covered Employee was performing in the customary manner all of the regular duties of the occupation on the last preceding scheduled work day.

A Covered Dependent, other than a Newborn Child, will be considered in Active Service if on the day coverage would normally start, the dependent is not confined for medical care or treatment (at home or elsewhere).

Annual Open Enrollment

The thirty (30) day period of time prior to the Plan Renewal Date in which all Eligible Employees may make changes to their coverage by adding or deleting coverage for themselves or their dependents.

Late Enrollees to This Plan (age nineteen (19) and older) will have a Pre-existing Condition period of eighteen (18) months, after which time, the condition will be covered the same as any other eligible medical expense as stated.

Upon receipt of a certificate of Creditable Coverage, any prior comparable coverage will offset the eighteen (18) month Pre-existing Condition period, month for month, provided there is not a break in coverage longer than sixty-two (62) days.

Calendar Year

The twelve (12) month period of January 1 through December 31 inclusive.

Close Relative

Any person that is immediately related to the insured (i.e. mother, father, brother, sister, spouse, or child) or directly related to the insured (i.e. aunt, uncle, grandparent, or cousin).

Persons living in the insured's household such as domestic partners and/or significant others are also included.

Covered Dependent

Any eligible dependent whose coverage became effective and has not terminated.

Covered Employee

Any eligible Employee whose coverage became effective and has not terminated.

Creditable Coverage

Creditable Coverage is the period of time that an individual has been covered by any of the following medical programs:

- The ERISA Plan in question;
- Another Group Health Plan;
- Non-Group or individual health insurance coverage issued by a state regulated insurer (including Blue Cross type plans) or an HMO;
- Medicare (Part A or Part B);
- Medicaid;
- The Active Military Health Program
- The Civilian Health and Medical Care Program for Uniform Services ("CHAMPUS");
- American Indian Health Care Programs;
- A State health benefits risk pool
- The Federal Employees Health Plan; A "public health plan"; or
- The Peace Corp Health Program.

Experimental

Any treatment, procedure, facility, equipment, drugs, drug usage or supplies not yet recognized by This Plan and any such items requiring federal or other governmental agency approval not granted at the time services were rendered, or services and supplies which are not in accordance with generally accepted professional medical or dental standards or with the generally accepted methods of treatment.

Fiduciary

The person or organization that has the authority to control and manage the operation and administration of the Plan. The Fiduciary has discretionary authority to determine eligibility for benefits or to construe the terms of This Plan. The named Fiduciary for This Plan is the Employer.

Illness

Bodily disorder, infection or disease and all related symptoms and recurrent conditions resulting from the same causes.

Injury

Physical harm sustained as the direct result of an accident, affected solely through external means and all related symptoms and recurrent conditions resulting from that same accident.

Medically Necessary / Medical Necessity

Services and supplies which are determined by the Employer, or its authorized agent to:

1. Be appropriate and necessary for the symptoms and diagnosis and treatment of a medical condition;
2. Be in accordance with standards of good medical practice, within the organized medical community;
3. Not be solely for the convenience of the patient, Physician or other health care provider; and
4. Be the most appropriate supply or level of service which can be safely provided.

For hospitalizations, this means that acute care as an inpatient is necessary due to the kind of services the Covered Person is receiving or the severity of the Covered Person's medical condition, and that safe and adequate medical care cannot be received as an outpatient or in a less intensified medical setting.

Just because the service is prescribed by a Physician does NOT mean the service is Medically Necessary. In an effort to make treatment convenient, to follow the wishes of the patient or the patient's family, to investigate the use of unproven treatment methods, or to comply with local Hospital practices, a Physician may suggest or permit a method of providing care that is not Medically Necessary.

Charges which are determined not to be Medically Necessary shall not be covered and no benefits will be payable for such charges. This will include, but is not limited to, services which are determined in a retrospective review and audit not to have been Medically Necessary.

Orthodontic Benefit – Lifetime Maximum

The total amount payable for covered orthodontic expenses incurred by a Covered Person during his or her lifetime, whether or not there has been any interruption in the continuity of coverage. See Orthodontic Services for Lifetime Maximum Benefit, if applicable.

Participating Employer

The Plan Sponsor and any Employer included in the "List of Participating Employers."

Physician

A licensed Doctor of Medicine (M.D.), Osteopathy (D.O.), Dentistry, Podiatry and Chiropractic providing a covered Service and acting within the scope of his/her license, who is not a member of the patient's immediate family.

Plan Sponsor

The person/organization responsible for the day-to-day functions and management of This Plan. The Plan Sponsor may employ persons or firms to process claims and perform other Plan connected services.

The Plan Sponsor is the named Plan Administrator within the meaning of Section 414(g) of the Internal Revenue Code of 1986, as amended, and is the named Administrator with the meaning of Section 3(16)(a) of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

The Plan Sponsor is:
Core Management Resources Group
515 Mulberry Street, Suite 300
Macon, GA 31201

Plan Year

The Plan Year for This Plan is February 1 through January 31.

The twelve (12) consecutive month period beginning on the Plan effective date and renewing on the same date each subsequent year.

Reasonable and Customary Charges

The most frequent charges which an individual Physician charges to the majority of patients for a given procedure. These charges must be within the range of fees charged by most Physicians of similar training and experience in a given geographical area for this same procedure, with consideration given to unusual circumstances involving medical complications requiring additional time, skill, and experience.

Special Enrollee

An Eligible Employee or an Eligible Dependent who refused coverage at the time it was originally offered because he or she had other Creditable Coverage, but whose other Creditable Coverage has terminated due to exhausting COBRA Coverage or by losing eligibility due to certain specified reasons (e.g. divorce, death). In addition, a Special Enrollee includes new dependents due to birth, adoption or marriage.

Special Enrollment Period

The thirty (30) day period of time surrounding a loss of other Coverage for a Special Enrollee, or the thirty (30) day period of time after a dependent is acquired due to birth, adoption or marriage, during which a Special Enrollee may request Coverage under This Plan.

Third Party Administrator

The person/organization hired by the Plan Sponsor in connection with the operation of This Plan and performing such functions, as processing and payment of claims, as may be delegated to it.

The Third Party Administrator is:
Core Administrative Services
PO Box 90
Macon, GA 31202-0090
478-741-3521 or 888-741-CORE

This Plan / Plan

The plan of benefits as contained in the Summary Plan Description and Group Provision Pages, and any agreements, schedules and amendments endorsed by Core Management Resources Group.

Total Disability or Totally Disabled

A Covered Employee will be considered Totally Disabled during any period when the employee is completely unable to perform the duties of the employee's occupation or work at any other gainful occupation. This definition is intended to correspond with Social Security's definition of Total Disability.

A Covered Dependent will be considered Totally Disabled during any period when, as a result of Injury or Illness the Dependent is confined as a bed patient in a Hospital and is completely unable to engage in the normal activities of a person of the same age and gender.

References

[1] 29 CFR 2520.102-3
(Contents of Summary Plan Description)
[2] 29 CFR Part
2590
45 CFR Part 303
(National Medical Support Notice [11/15/1999])
[3] 29 CFR Part
825
(Family Medical Leave Act 1993)