# Georgia Bankers Association Insurance Trust

# Over 65 Medicare Supplement

# High Option

# Certificate Booklet

GBA | INSURANCE TRUST

GEORGIA BANKERS ASSOCIATION

the resource that empowers

Effective January 1, 2012

**CERTIFICATE OF COVERAGE**

**BLUE CROSS AND BLUE SHIELD OF GEORGIA, INC.**
**An Independent Licensee of the Blue Cross and Blue Shield Association**
**(herein called BCBSGA)**
**having issued a**
**Group Master Contract**
**to**

**GEORGIA BANKERS ASSOCIATION INSURANCE TRUST (GBAIT)**
**OVER 65 MEDICARE SUPPLEMENT**
**HIGH OPTION**
**Group Number: 1000828-001**

1. the persons and their eligible family members (if any) whose names are on file at the office of the Plan Administrator as being eligible for coverage, have had the required application for coverage accepted, and subscription charge received by GBAIT. These persons are covered under and subject to all the exceptions, limitations and provisions of said Group Master Contract for the benefits described herein;
2. benefits will be processed by Paragon Benefits, Inc., the Claims Administrator, in accordance with the provisions and limitations of the Group Master Contract; and
3. BCBSGA has delivered to the Plan Administrator the Group Master Contract covering certain persons and their eligible family members (if any) as Members of this group program.

The Group Master Contract (which includes this Certificate Booklet and any riders and amendments) constitutes the entire Contract. All rights which may exist, arise from and are governed by the Group Master Contract and this Certificate Booklet do not constitute a waiver of any of the terms. The Group Master Contract may be inspected at the office of the Plan Administrator.

Coverage under this Certificate will be effective and will continue in effect in accordance with the terms, provisions and conditions of the Group Master Contract. This Certificate of Coverage replaces and supersedes all Contracts and/or Certificates which may have been issued previously through the Plan Administrator.

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**Summary Notice**

This Certificate Booklet summarizes your Employer's Medicare supplement benefit program. This Certificate Booklet is written in an easy-to-read language to help you and your dependents understand your health care benefits. It is issued as part of your Employer's Group Master Contract and governs your group's coverage.

A thorough understanding of your coverage will enable you to use your benefits wisely. Please read this Certificate Booklet carefully. If you have any questions about your benefits as presented in this Certificate Booklet, please contact your Employer's employee benefit specialist or call Paragon Benefits, Inc.

This Certificate Booklet is an integral part of your Employer Group Master Contract. Its purpose is to help you understand your coverage and to provide an explanation of certain other benefits that your Employer may offer. Certain administrative details and legal rights provisions are included in a separate document which is held by your Employer.

**Important Phone Numbers and Address**

**Customer Service**
If you have a customer service question, please call Paragon Benefits, Inc. at 877-380-0193. Their mailing address is – PO Box 12288 Columbus, GA 31917

**Medical Claims** should be mailed to:
Paragon Benefits, Inc.
PO Box 981600
El Paso, TX 79998
Payor #58174

## Eligibility Information

### Coverage for the Retiree

This booklet describes the benefits you may receive under this program. You are called the Subscriber or Member.

No coverage is provided for dependents. Your spouse may be eligible for coverage under his or her name provided he or she is not legally separated or divorced from you. The spouse must be entitled to Medicare by reason of age.

**How Your Benefits Work For You (Payment Terms)**

**Introduction**

This section describes the benefits you may receive under the Contract. Before providing benefits, you may be required to present a copy of the Medicare Explanation of Benefits.

To receive benefits, you must be under a physician's care and the services must be recommended by your physician. The following services are subject to the rules of the Hospital or other institution, including regulations governing admission.

**Benefits**

1. **Hospital Inpatient Care**
   If you are admitted to a Hospital, the Contract covers the following benefits for you:
   - for the 1st through the 60th day of confinement, the Medicare Part A deductible;
   - the coinsurance amount that applies to the inpatient Hospital services after the 60th day and before the 91st day (25% of the Part A Deductible per day);
   - the coinsurance amount that applies to inpatient Hospital services after the 90th day to the 150th day (50% of the Part A Deductible per day).

   Regular Medicare Hospital benefits end on the 90th day of confinement during a Medicare Part A Benefit Period. After the 90th day, Medicare grants a 60 day Lifetime Reserve Period. These 60 additional days can be used only once in a lifetime. Medicare allows a person the choice of using the days or saving them for the future. If you use the days, Medicare covers all Hospital expenses incurred during the Lifetime Reserve Period except the coinsurance, which is covered under this Contract.

   If you save the days for a future use, this Contract limits the daily payment to 50% of the Medicare Part A Deductible.

   After the Lifetime Reserve Period ends (or would have ended if used), the Contract covers 100% of your remaining Medicare eligible charges for inpatient Hospital services. Such payment will be made based on the Medicare allowed amount, subject to a lifetime maximum of 365 additional days per Member.

   These benefits are available only if the services would have been eligible under Medicare.

   If you stay in a private room, the Contract allows up to the Hospital's most common semiprivate room rate.

2. **Part A and Part B Blood Deductible**
   This Contract covers the reasonable cost for the first three pints of blood per year under the Part A or Part B Medicare Deductible.

3. **Hospital Outpatient Care**
When you are treated in the outpatient department of a Hospital, this Contract covers the 20% coinsurance not covered by Medicare.

4. **Skilled Nursing Facility**
When a Member is confined in a Skilled Nursing Facility, this Contract covers the benefits stated below. The confinement must be approved by Medicare in a facility that is approved for payment of Medicare benefits or is qualified to receive such approval, if so requested.

**1st to 20th Day**
Medicare pays for the first 20 days of an approved confinement during a Medicare Part A Benefit Period. There are no benefits under this Contract for the first 20 days.

**21st to 100th Day**
Medicare pays all Skilled Nursing Facility expenses except for a daily coinsurance expense. This Contract covers the coinsurance for the 21st through the 100th day of confinement (12 ½% of Part A Deductible per day).

**101st to 365th Day**
Medicare does not cover an eligible Skilled Nursing Facility stay after the 100th day. For the 101st to the 365th day of confinement, this Contract will cover room and board charges up to $75 a day.

**Medicare only approves Skilled Nursing Facility care that provides skilled, medically necessary care:**

- At a level meeting Medicare standards; and
- Commencing within 30 days of discharge from a Hospital confinement of at least 3 consecutive days.

The benefit under this Contract is limited to those days of confinement which Medicare approves, or would have approved had Medicare benefits for the confinement not been exhausted.

5. **Medical and Other Health Services**
After a yearly deductible, Part B Medicare pays 80% of the reasonable charges for certain medical services. This Contract covers the Medicare Part B Deductible and the 20% of the Medicare Part B Eligible Expenses after the Medicare Part B Deductible is met each Calendar Year.

**Out-of-Pocket Expense**
An Out-of-Pocket Expense is:

- The portion of an expense covered under Medicare Part B, which is more than Medicare considers reasonable, up to the Usual, Customary, and Reasonable (UCR) amount; plus
- Expenses used to meet the Medicare Part B Deductible. The Out-of-Pocket Expense amount is $500 per Calendar Year. After the Out-of-Pocket Expense reaches the $500 Out-of-Pocket Expense amount, the Contract will pay the difference between:
    - The Medicare Part B eligible expense; and

- The UCR charge.

However, the Contract will not cover the eligible Out-of-Pocket Expense if:

- The provider of the medical care accepts Medicare's assignment; or
- The service or supply is not covered by Medicare.

Out-of-Pocket Expenses do not include expenses that are excluded or limited under the Contract.

**Carry Over**

Covered Out-of-Pocket Expenses incurred during the last three months of a Calendar Year applied to that year's Out-of-Pocket Expense, may also be carried over and also applied toward the next year's Out-of-Pocket Expense.

**6. Foreign Medical Treatment Benefits**

The Contract covers the reasonable expense incurred by a Member for foreign medical treatment, provided the Member receives the first foreign medical treatment:

- While covered by this benefit; and
- Within the first 180 days of travel outside of the United States per Calendar Year.

This benefit will be limited to treatment received during a Foreign Medical Treatment Benefit Period. The Foreign Medical Treatment Benefit Period:

- Begins on the date of the first foreign medical treatment; and
- Ends 90 consecutive days later.

This benefit will not cover any part of a confinement that extends beyond that 90 day benefit period or any service or supply received after that 90 day benefit period.

This benefit will not cover Foreign Medical Treatment if a Member:

- Leaves the United State primarily to seek Foreign Medical Treatment for an illness or injury;
- Has no legal obligation to pay for the treatment; or
- Receives the treatment during a Calendar Year in which the Member travels or resides outside the United States for six (6) consecutive months or longer.

In addition, this benefit will not cover Foreign Medical Treatment if Medicare approves the treatment (in which event, the regular benefits of this Contract apply).

However if:

- A Member must remain outside of the United States more than 6 months because of an injury or illness that prevents return to the United States; and
- The Member has established a Foreign Medical Treatment Benefit period for that illness or injury within the first 180 days of travel as stated above;

then, this benefit for that illness or injury will continue until the end of the Foreign Medical Treatment Benefit period.

**7. Private Duty Nursing Benefit During A Hospital Confinement**

Benefits are provided for the lesser of:

- The expense incurred;
- The Private Duty Nursing Maximum Benefit Amount.

For each shift of Private Duty Nursing service, up to the maximum number of shifts per Calendar Year.

The Private Duty Nursing Service must be provided to a Member while he or she is:

- Covered under this Contract; and
- Confined in a Hospital

The Private Duty Nursing Services must be charged directly to a Member by the nurse and not charged by a Hospital.

The Contract will not cover more than 3 shifts of Private Duty Nursing Services per day. A shift consists of at least 3 consecutive hours of nursing care. Shifts of more than 3 hours but less than 8 hours will be paid on a pro-rata basis.

The maximum benefit allowed is up to $30 per 8 hours shift. The maximum number of shifts per Calendar Year is 60.

**8. Hospice Care**

Under Medicare, a terminally ill person may elect to receive Hospice Care benefits instead of most regular Medicare Part A and Part B benefits. Then, Medicare pays all approved Hospice Care charges except coinsurance charges for inpatient respite care, drugs and biologicals.

When a Member elects to receive Hospice Care, the Contract will cover the Medicare coinsurance charges which he or she incurs.

The Hospice Care must:

- Be approved by Medicare; and
- Be received while covered by this benefit.

When this benefit is payable, no other benefits of the Contract will be provided for any expense which is covered under this Hospice Care benefit.

**9. Outpatient Prescription Drug Benefits are NOT covered under this Contract**

**Limitations and Exclusions**

**Pre-existing Conditions**

Pre-existing condition is any injury or illness for which a Member received medical advice or treatment within the 6 month period immediately before his or her effective date of coverage.

**Conditions Prior to Effective Date**

During the first 6 months from a Member's effective date of insurance, expenses incurred for pre-existing conditions are not covered.

**Change from a Related Contract**

If a Member's coverage has converted without interruption:

a) From the related contract;
b) To this Contract;

Credit will be applied toward satisfaction of the above pre-existing condition limitation for the period that the Member was continuously covered by the related contract immediately before conversion.

Any expenses incurred which are payable under an extension of benefits provision of the related policy will not be payable under this Contract.

Related contract is a Member's under age 65 health contract.

**Replacement Coverage**

If the covered Member:

- Has purchased the coverage under this Contract in order to replace coverage under a prior Medicare Supplement policy;
- He or she provides proof of coverage under such prior Medicare Supplement policy; credit will be applied toward satisfaction of the Contract's pre-existing condition limitation for the period that he or she was continuously covered by the prior Medicare Supplement contract immediately before his or her effective date under this Contract.

However, if benefits under this Contract are greater than those provided by the prior policy, the 6 month pre-existing condition limitation of this Contract will apply only to the increased benefits.

**General Limitations**

1. If a Member has not enrolled in both Medicare Part A and Part B, benefits will be paid under the Contract as if the Member had enrolled in both parts of Medicare.

**What's Not Covered**

Your coverage does not provide benefits for:

1. Services not covered by Medicare unless specifically listed in this booklet as covered.
2. Expenses incurred after coverage terminates.
3. Care for any condition or injury recognized or allowed as a compensable loss through any Workers' Compensation, occupational disease or similar law.
4. Any disease or injury resulting from a war, declared or not, or any military duty. Also excluded are charges for services directly related to military service provided or available from the Veterans' Administration or military medical facilities as required by law.
5. Any item, service, supply or care not specifically listed as a benefit in this booklet.
6. Admission or continued Hospital or Skilled Nursing Facility stay for medical care or diagnostic studies not medically required on an inpatient basis.
7. Routine physical examinations, screening procedures and immunizations (including those necessitated by foreign travel) which are not called for by known symptoms, illness or injury except those which may be specifically listed as covered in this booklet.
8. Custodial care, rest cures, or travel expenses even if recommended for health reasons by a physician.
9. Transportation services not covered by Medicare.
10. Care of which you have no legal obligation to pay or for which no charge would be made if you had no health insurance coverage.
11. Charges for failure to keep a scheduled visit or for completion of claim forms; for physician or Hospital's stand-by services, for holiday or overtime rates.
12. Services rendered by a provider who is a close relative or member of your household. Close relative means wife or husband, parent, child, brother or sister, by blood, marriage or adoption.
13. Treatment where payment is made by any local, state, or federal government (except Medicaid).
14. Services paid under Medicare or which would have been paid if the Member had applied for Medicare and claimed Medicare benefits.
15. Expenses in excess of the Usual, Customary, and Reasonable Charges (as determined by BCBSGA).
16. Treatment for the prevention or cure of alcoholism or drug addiction.
17. Injuries received while committing a felony.
18. Intentionally self-inflicted injuries, suicide, or attempted suicide, whether sane or insane.
19. Home health services above the number of visits covered by Medicare.
20. Prescription Drug expenses.

## Claims and General Information

### How to File Claims

Under normal conditions claims should be filed within 90 days after the services was provided. This section of your booklet describes when to file a benefits claim and when a Hospital or physician will file the claim for you.

Each person enrolled through the group's Contract receives an Identification Card.

### Processing Your Claim

You are responsible for submitting your claims for expenses not normally billed by and payable to a Hospital or physician. Always make certain you have your Identification Card with you. Be sure the Hospital or physician's office personnel copy your name, group and contract numbers accurately when completing forms relating to your coverage.

If you are hospitalized outside Georgia, the claims for Hospital and physician services should be submitted to Paragon Benefits, Inc., along with copies of the Medicare explanation of benefits.

### Timeliness of Filing

To receive benefits, any necessary reports and records must be filed within 1 year of the date of Medicare's processing. Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information. In this case, you will be notified within 15 working days of the reason for the delay and will receive a list of all information needed to continue processing your claim. After this data is received, the claims supervisor has 15 working days to complete claims process. The claims supervisor shall pay interest at the rate of 18% per year if it does not meet these requirements.

### Necessary Information

In order to process your claim, information may be needed from the provider of the service. As a Member, you agree to authorize the physician, Hospital, or other provider to release necessary information.

Such information will be considered confidential. However, BCBSGA has the right to use this information to defend or explain a denied claim.

Paragon Benefits, Inc. may request claim forms when necessary.

**Questions About Coverage or Claims**

If you have questions about your coverage, contact your plan administrator or Paragon Benefits, Inc. Be sure to always give your member ID number.

When asking about a claim, give the following information:

- Member ID number;
- Patient name; Subscriber name and address;
- Date of service; type of service received; and
- Provider name and address (Hospital or physician).

**Right to Appeal**

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 program; and, if payment is partially or wholly denied, the reason.

If your claim is denied, or if you haven't heard anything within 90 days after you provide proof of claim, you can appeal. Any legal action must be brought within three years after the date the services or supplies were provided. Your rights of appeal are discussed in the section titled "Summary Plan Description and Statement of ERISA Rights".

**Terms of Your Coverage**

Benefits described in this booklet are only provided for eligible Members. Any group contract or certificate which you had received previously will be replaced by this Contract.

Benefit payment for covered services or supplies will be made directly to the participating Hospital or the participating facility. A Member may assign benefits to a non-participating provider, but it is not required. If a Member does not assign benefits to a non-participating provider, any benefit payment will be sent to the Member.

BCBSGA does not supply you with a Hospital or physician. In addition, BCBSGA is not responsible for any injuries or damages you may suffer due to actions of any Hospital, physician or other person.

An oral explanation of your benefits by a BCBSGA, Paragon Benefits or GBA Employee is not legally binding.

Any correspondence mailed to you will be sent to your most current address. You are responsible for notifying Paragon Benefits, Inc. of your new address.

**General Information**

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

All parties to this Contract (the employer, Paragon Benefits, Inc., GBA and BCBSGA) are relieved of their responsibilities without breach, if their duties become impossible to perform by acts of God, war, terrorism, fire, etc.

BCBSGA will adhere to the employer's instructions and allow the employer to meet all of the employer's responsibilities under applicable state and federal law. It is the employer's responsibility to adhere to all applicable state and federal laws and BCBSGA does not assume any responsibility for compliance.

**Changes in Coverage**

The Plan Sponsor and BCBSGA may mutually agree to change the benefits described in this booklet. Fees charged for benefits described in this booklet may be changed:

- If the level of benefits changes; or
- If the ratio of benefits to fees exceed an established level.

**Acts Beyond Reasonable Control (Force Majeure)**

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.

**Changes to Medicare**

Benefits are adjusted annually to reflect changes in the federal government's Medicare program. These changes may cause increases or decreases in benefit amounts payable under the Contract.

The amount of Medicare eligible expenses covered as the result of an increase in benefits cannot be used to satisfy any deductible under this Contract.

However, this increase in benefits due to a reduction in Medicare payments will not apply if the provider accepts Medicare assignment for the medical care.

**When Your Coverage Terminates**

**Termination of Coverage**

Your coverage under the Contract will cease on the earliest of:

1. The date the Contract terminates; or
2. The last day of the period for which you fail to pay the required premium for your coverage, subject to the grace period provision below;
3. The date coverage is cancelled for the class of person to which you belong; or
4. The date your participating employer is no longer a member of GBAIT; or
5. The premium due date on or next following the date you refuse to sign acceptance of a rider which reduces or eliminates benefits for all Members of the same class and plan, except if the rider is required by law.

**Extension of Benefits**

If a Member is totally disabled on the date his or her coverage terminates, BCBSGA will extend the benefits for expenses incurred as the result of that disability, subject to all Contract benefit provisions, exclusions and limitations.

**For Medicare Part A Eligible Expenses**
A Medicare Part A eligible expense, which is established prior to termination, extends until the first to occur of:

- The date the Member has not been confined in a Hospital or Skilled Nursing Facility for a period of 60 consecutive days; or
- The 365$^{th}$ day after termination.

If a Member's coverage terminates while he or she is receiving approved Hospice Care, the Hospice Care benefits for this Contract will continue until the end of the Hospice Care benefit period, as defined by Medicare.

**For Medicare Part B Eligible Expense**
A Medicare Part B eligible expense extends until the end of the Calendar Year quarter following termination as shown below:

- If the Contract terminates January, February or March, the extension date is June 30 of the same year;
- If the Contract terminates April, May or June, the extensions date is September 30 of the same year;
- If the Contract terminates July, August or September, the extension date is December 31 of the same year; or
- If the Contract terminates October, November or December, the extension date is March 31 of the next year.

## Definitions

**Accidental Injury**
Bodily injury sustained by a Member 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 Member receives. Such care must occur while this Contract is in force. It does not include injuries for which benefits are provided under any Workers' Compensation, employer's liability or similar law.

**Applicant**
The corporation, partnership, sole proprietorship, other organization or group which applied for this Contract.

**Application for Enrollment**
The original and any subsequent forms completed and signed by the Subscriber seeking coverage.

**Benefit Period**
One year, January 1 – December 31 (also called the Calendar Year). It does not begin before a Member's effective date. It does not continue after a Member's coverage ends.

**Calendar Year**
A period of 12 consecutive months, starting on January 1 and ending on December 31 of the same year.

**Certificate**
A short written statement which defines BCBSGA's legal obligation to the individual Member. It is part of this benefit booklet.

**Chemical Dependency (Substance Abuse)**
The total psycho-physical state of mind that involves feelings of satisfaction and a drive to periodic or continuous administration of the chemical (drug) to produce pleasure or avoid discomfort.

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

**Custodial Care**

1. Any service provided primarily for the convenience or comfort of the patient but does not directly treat an illness or injury.
2. Care provided a patient whose need for medical care has stabilized and whose current medical condition is not expected to significantly and objectively improve over a specified period of time is considered custodial.

Custodial care serves to assist individuals in the activities of daily living such as walking, getting in and out of bed, bathing, dressing, feeding (including via any form of a tube), meal preparation, housekeeping tasks, supervision/administration of medicine which is usually self-administered; and/or similar types of services. It does not require the continuing attention of trained medical or paramedical personnel once the patient's primary care giver has reached a level of proficiency in providing the treatment (such as tracheostomy or catheter care).

Determination of Custodial Care will take into consideration the level of care, medical supervision required, and rehabilitation potential.

**Effective Date**

The date approved for an individual's application for coverage.

**Eligible Charges**

Those reasonable charges of Hospitals or other health care facilities or suppliers; or Usual, Customary and Reasonable (UCR) charges for services covered under this Contract.

**Employer**

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

**Employer, Participating**

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

**Home Health Care Agency**

A provider who renders care through a program for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending physician. It must be licensed by the appropriate state agency.

**Hospice**
A provider which provides care for terminally ill patients and their families, either directly or on a consulting basis with the patient's physician. It must be licensed by the appropriate state agency.

**Hospital**
An institution licensed by the appropriate state agency, which is primarily engaged in providing diagnostic and therapeutic facilities on an inpatient basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of physicians duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty. The Hospital must be approved by Medicare. "Hospital" does not mean other than incidentally:

- An extended care facility; nursing home; place for rest; facility for care of the aged;
- A custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training or non-medical personal services; or
- An institution for exceptional or handicapped children.

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

**Inpatient**
A Member who is treated as a registered bed patient in a hospital and for whom a room and board charge is made.

**Medicare**
This is Title XVIII of the Social Security Act of 1965, as amended.

**Medicare Eligible Expense**
Health care expenses covered by Medicare to the extent recognized as reasonable by Medicare.

**Medicare Part A Benefit Period**
A period of time during which a Medicare beneficiary is confined in a Hospital or Skilled Nursing Facility. A Medicare Part A Benefit Period;

- Begins when a Medicare beneficiary is admitted to a Hospital as an inpatient; and
- Ends when the beneficiary has not been confined in a Hospital or Skilled Nursing Facility for 60 consecutive days.

**Medicare Part A Deductible**
The deductible amount which a Member is required to pay under Medicare for the expenses incurred at the beginning of a Medicare Part A Benefit Period.

**Medicare Part B Deductible**
The deductible amount which a Member is required to pay under Medicare Part B each Calendar Year for Medicare eligible expenses.

**Member**
The Subscriber who is covered by this Contract.

**Mental Health Disorders**
Includes (whether organic or non-organic, whether of biological, non-biological, genetic, chemical or non-chemical origin, and irrespective of cause, basis or inducement) mental disorders, mental illnesses, psychiatric illnesses, mental conditions, psychiatric conditions. This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, chemical dependence disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. This is intended to include disorders, conditions, and illnesses listed in DSM-IIR (Diagnostic and Statistical Manual of Mental Disorders).

**Physician**
Any licensed Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery, any licensed Doctor of Osteopathy (D.O.) approved by the Composite State Board of Medical Examiners, any licensed Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and any licensed Doctor of Dental Surgery (D.D.S.) legally entitled to perform oral surgery. Optometrists and Clinical Psychologists are also considered covered providers when acting within the scope of their licenses, and when rendering services covered under this Contract.

**Prescription Drug**
A drug which cannot be purchased except with a prescription from a Physician.

**Professional Ambulance Service**
A state-licensed emergency vehicle which carries via the public streets injured or sick persons to a Hospital. Services which offer non-emergency, convalescent or invalid care do not meet this definition.

**Related Contract**
The Member's under age 65 group health plan.

**Skilled Convalescent Care**
Care required, while recovering from illness or injury, which is received in a Skilled Nursing Facility. This care requires a level of care or services less than that in a Hospital, but more than could be given at the patient's home or in a nursing home not certified as a Skilled Nursing Facility.

**Skilled Nursing Facility**
An institution operated alone or with a Hospital which gives care after a Member leaves the Hospital for a condition requiring more care than can be rendered at home. It must be licensed by the appropriate state agency.

**Subscriber**
The individual who signed the application for enrollment and in whose name the Identification Card is issued.

**Summary Plan Description and Statement of ERISA Rights**

**Plan Information**

1. Plan Name: High Option
2. Plan Sponsor: Georgia Bankers Association Insurance Trust, Inc.
3. Employer I.D. Number: 58-2241094
4. Plan Number: AGP-1668
5. Plan Year Ends: December 31
6. Plan Administrator and Named Fiduciary:
   Georgia Bankers Association Insurance Trust, Inc.
7. Agent For Legal Process:
   Georgia Bankers Association Insurance Trust, Inc.
   50 Hurt Plaza, Suite 1050
   Atlanta, GA 30303
   (404) 522-1501
8. Type of Plan: Medicare Supplement Coverage
9. Plan Eligibility Requirements and Summary of Benefits: This booklet describes the benefits applicable to you under the Plan. For a description of the eligibility requirements of the Plan, the amount and the type of benefits available, and the circumstances under which benefits of the Plan are not available or may terminate, please refer to this booklet.
10. Claims Procedure: For a description of how to file a claim, see the claims and general information section of this booklet.
11. Review of Claims Denial: If a claim is denied, you or your authorized representative will receive a written notice stating the basis for the denial. You will then be entitled, upon written request to review of that claim decision. If you are not notified at all within 90 days after you submit the claim, this may be considered a claim denial and you may request a review as described above. Your request for a review must be submitted within 60 days after the claim is denied. The request should be accompanied by any documents or records in support of your appeal. A decision on the request will be made in writing within 60 days after it is received, except that if special circumstances require an extension of time, you will be so notified. In no event will a final decision on your claim be rendered more than 120 days after the request for the review. The final decision should be in writing to the claimant, with reference to the relevant plan provision on which the decision was based. The insurance company has the right to interpret the plan provisions, so its decision is conclusive and binding.

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

12. Loss of Benefits: Modification of the Plan: This booklet describes the events which may cause all or part of the coverages under the Plan to terminate, and any rights you may have at such termination.

    One such event is termination of the BCBSGA Contract which will result in the following:
    Termination of that part of the Plan's health-care expense coverages for which BCBGA has liability in accordance with the group contract's terms.

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

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

Georgia Bankers Association Insurance Trust, Inc. expects to continue the Plan indefinitely, but reserves the right to amend or terminate the Plan, or any part of it, at any time without the consent of persons covered under it. Amendment or termination of the Plan shall be made by the Board of Directors of the Georgia Bankers Association Insurance Trust, Inc. However, any part of the plan provided under the Group Contract issued by BCBSGA cannot be changed without BCBSGA's consent.

13. The Plan shall not give any employee of, or any dependent of any employee, any right or claim except to the extent that such right or claim is specifically fixed under the terms of the Plan. The establishment of the Plan shall not be construed to give any employee a right to be continued in the employ of the employer or as interfering with the right of the Employer to terminate the employment of any employee at any time.
14. ERISA Rights and Protections: As a participant in the group benefits plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:
    - Examine, without charge, at the Plan Administrator's office all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed reports and plan descriptions.
    - Obtain copies of all plan documents and other plan information upon written request to the plan administrator. The plan administrator may make a reasonable charge for the copies.
    - Receive a summary of the Plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

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

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

    Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100 a day until you receive the materials unless the materials were

not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare 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.

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

**ERISA Appeals**

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

The ERISA Review Committee is composed of persons not involved in making the original decision of your claim. This committee reviews all facts on which the decision was based, any additional information you may have provided with your request for review and also may seek additional information from the hospital or provider. You will receive written notice of the committee's findings.

None of these steps precludes your taking your case to the civil court. Also, you have the right to be represented by an attorney in dealing with BCBSGA at any time.

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