BlueCross BlueShield of Georgia

2016

# Georgia Dental Insurance Services, Inc. Open Enrollment Package

GDIS

Georgia Dental Insurance Services, Inc.

A Subsidiary of The Georgia Dental Association

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November 19, 2015

Dear Plan Participant:

When choosing quality affordable health insurance coverage, your GDA is here to help. By now, or when you start shopping for your health insurance, you may notice that all of those plans from other insurers that were less expensive the past two years are increasing in price dramatically -- many as much as 50% for the 2016 enrollment renewal!

However, working diligently on behalf of GDA members, the Georgia Dental Association has renewed its health plan with Blue Cross Blue Shield of Georgia. During the renewal process we negotiated renewal rates at the lowest possible increase.

To that end, a key benefit of purchasing a health plan through the GDA is the broad network of doctors and hospitals in the plan. Unlike lower priced narrow network plans that have limited providers and facilities or higher out-of-network rates that leave patients vulnerable, you'll have access to a larger pool of your desired specialists and hospitals. The GDA's broad network health plans give you greater control over your health care choices.

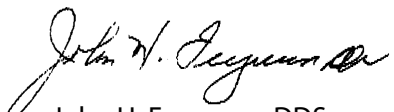
**Plans for 2016 include:**
- **Broad network plans provide access to desired specialists and hospitals**
- **$10K life insurance benefit for a low $1.90/month**
- **Added vision benefit**
- **Access to your personal agents at the GDA office dedicated to serving GDA members**

To renew your health insurance coverage for 2016, please complete the open enrollment form on page 19 and return it by Monday, December 14 by fax, email, or mail to Christy Biddy at the GDA office. Benefits are effective January 1, 2016.

Please note that completing an open enrollment form or waiver is required for every person in your office. The enrollment package includes the summary of benefits and coverage for each plan option. These summaries will also be posted on the GDA website at www.MyGDIS.com.

If you have questions about your coverage or any of the benefit plans or need assistance with an individual plan, please call the GDA office at 404-636-7553 and ask for a member of the health insurance team.

Sincerely,



John H. Ferguson, DDS
Chairman

Frank J. Capaldo
CEO, Georgia Dental Insurance Services, Inc.
Executive Director, Georgia Dental Association

# News and notes for 2016

## All plans are Open Access POS

**Point of Service (POS).** This type of health plan covers services from a network of doctors and hospitals in your area. You can choose your own doctors as long as they are in the POS network.

If you pay a little more you can also get care outside of the POS network. Some POS plans may have different rules, so be sure to check your plan details.

## Vision benefit

**Vision Coverage.** With Blue View Vision℠, you have access to a network of over 30,000 doctors and more than 25,000 locations across the country, including convenient retail stores like LensCrafters®, Sears Optical℠, Target Optical®, JCPenney® Optical and most Pearle Vision® stores.

The vision coverage includes a routine eye exam, frames and either eyeglass lenses or contact lenses. (Vision plan details are located on the next two pages.)

Kids can get Transitions® lenses to protect their eyes from harmful UV rays and polycarbonate lenses to help protect them from damage at no additional cost.

# Your vision plan

**WELCOME TO BLUE VIEW VISION!**

Good news—your vision plan is flexible and easy to use. This benefit summary outlines the basic components of your plan, including quick answers about what's covered, your discounts, and much more!

Georgia Dental Association
January 1, 2016

## Blue View Vision℠

**Your Blue View Vision network**

Anthem Blue Cross vision members have access to one of the nation's largest vision networks. Blue View Vision is the only vision plan that gives members the ability to use their in-network benefits at 1-800 CONTACTS, or choose a private practice eye doctor, or go in store to LensCrafters®, Sears Optical℠, Target Optical®, JCPenney® Optical and most Pearle Vision® locations.

**Out-of-network:** If you choose to, you may receive covered benefits outside of the Blue View Vision network. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement of your out-of-network allowance. In-network benefits and discounts will not apply.

### YOUR BLUE VIEW VISION PLAN AT-A-GLANCE

| VISION PLAN BENEFITS | | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|---|
| **Routine eye exam** once every calendar year | | $10 copy, then covered in full | $48 allowance |
| **Eyeglass frames**<br>Once every calendar year you may select an eyeglass frame and receive an allowance toward the purchase price | | $130 allowance, then 20% off any remaining balance | $64 allowance |
| **Eyeglass lenses** *(Standard)*<br>Once every calendar year you may receive any one of the following lens options: | | | |
| | o Standard plastic single vision lenses *(1 pair)* | $20 copy, then covered in full | $36 allowance |
| | o Standard plastic bifocal lenses *(1 pair)* | $20 copy, then covered in full | $54 allowance |
| | o Standard plastic trifocal lenses *(1 pair)* | $20 copy, then covered in full | $69 allowance |
| **Eyeglass lens enhancements**<br>When obtaining covered eyewear from a Blue View Vision provider, you may add any of the following lens enhancements at no extra cost. | | | |
| | o Transitions Lenses (for a child under age 19) | $0 after eyeglass lens copay | No allowance on lens enhancements when obtained out-of-network |
| | o Standard Polycarbonate (for a child under age 19) | $0 after eyeglass lens copay | |
| | o Factory Scratch Coating | $0 after eyeglass lens copay | |
| **Contact lenses** – once every calendar year<br>Prefer contact lenses over glasses? You may choose contact lenses instead of eyeglass lenses and receive an allowance toward the cost of a supply of contact lenses. | o Elective Conventional Lenses; or | $130 allowance, then 15% off any remaining balance | $105 allowance |
| | o Elective Disposable Lenses; or | $130 allowance *(no additional discount)* | $105 allowance |
| | o Non-Elective Contact Lenses | Covered in full | $210 allowance |

*Your contact lens allowance can only be applied toward the first purchase of contacts you make during a benefit period. Any unused amount remaining cannot be used for subsequent purchases made during the same benefit period, nor can any unused amount be carried over to the following benefit period.*

**EXCLUSIONS & LIMITATIONS (not a complete list)**

**Combined Offers.** Not combined with any offer, coupon, or in-store advertisement.
**Excess Amounts.** Amounts in excess of covered vision expense.
**Sunglasses.** Sunglasses and accompanying frames.
**Safety Glasses.** Safety glasses and accompanying frames.
**Not Specifically Listed.** Services not specifically listed in this plan as covered services.
**Lost or Broken Lenses or Frames.** Any lost or broken lenses or frames are not eligible for replacement unless the insured person has reached his or her normal service interval as indicated in the plan design.
**Non-Prescription Lenses.** Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.
**Orthoptics.** Orthoptics or vision training and any associated supplemental testing.

| *OPTIONAL SAVINGS AVAILABLE FROM IN-NETWORK PROVIDERS* | | *In-network Member Cost (after any applicable copay)* |
|---|---|---|
| **Retinal Imaging** | o At member's option can be performed at time of eye exam | Not more than $39 |
| **Eyeglass lens upgrades**<br>When obtaining eyewear from a Blue View Vision provider, members may choose to upgrade their new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies. | o Transitions lenses (Adults)<br>o Standard Polycarbonate (Adults)<br>o Tint (Solid and Gradient)<br>o UV Coating<br>o Progressive Lenses<br>  o Standard<br>  o Premium Tier 1<br>  o Premium Tier 2<br>  o Premium Tier 3<br>o Anti-Reflective Coating<br>  o Standard<br>  o Premium Tier 1<br>  o Premium Tier 2<br>o Other Add-ons and Services | $75<br>$40<br>$15<br>$15<br><br>$65<br>$85<br>$95<br>$110<br><br>$45<br>$57<br>$68<br>20% off retail price |
| **Additional Pairs of Eyeglasses**<br>Anytime from any Blue View Vision network provider | o Complete Pair<br>o Eyeglass materials purchased separately | 40% off retail price<br>20% off retail price |
| **Eyewear Accessories** | o Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc. | 20% off retail price |
| **Contact lens fit and follow-up**<br>Available following a comprehensive eye exam | o Standard contact lens fitting<br>o Premium contact lens fitting | Up to $55<br>10% off retail price |
| **Conventional Contact Lenses** | o Discount applies to materials only | 15% off retail price |

***ADDITIONAL SAVINGS AVAILBLE THROUGH OUR SPECIAL OFFERS PROGRAM***

Members can take advantage of savings opportunities from dozens of vendors on a variety of products and services, including LASIK vision surgery, hearing services and aids, wellness products, weight loss programs, fitness memberships, elder care services, 1-800 CONTACTS* and much more.

[1] Please ask your provider for his/her recommendation as well as the progressive brands by tier.

[2] Please ask your provider for his/her recommendation as well as the coating brands by tier.

[3] A standard contact lens fitting includes spherical clear contact lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

[4] A premium contact lens fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

**OUT-OF-NETWORK**

If you choose an out-of-network provider, please complete an out-of-network claim form and submit it along with your itemized receipt to the fax number, email address, or mailing address below. When visiting an out-of-network provider, discounts do not apply and you are responsible for payment of services and/or eyewear materials at the time of service.

**To Fax:** 866-293-7373
**To Email:** oonclaims@eyewearspecialoffers.com
**To Mail:** Blue View Vision
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

**Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care physician from your medical network. If you have questions about your benefits or need help finding a provider, visit bcbsga.com or call us at 1-866-723-0515.**

This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force.

This information is intended to be a brief outline of coverage. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's policy, which shall control in the event of a conflict with this overview. Discounts referenced are not covered benefits under this vision plan and therefore are not included in the member's policy. Frame discounts may not apply to some frames where the manufacturer has imposed a no discount policy on sales at retail and independent provider locations. Discounts are subject to change without notice. This benefit overview is only one piece of your entire enrollment package.



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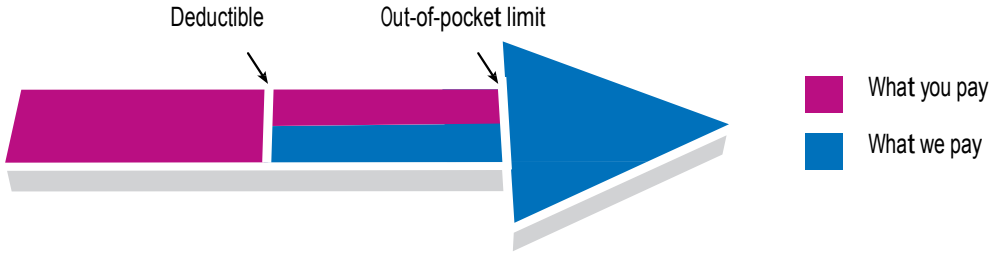
# Getting started with health insurance

## Let's start with how health insurance works in general




1. **You pay your deductible.** This is a set amount that you pay before your plan starts paying for covered services.

2. **After you meet your deductible, you and your plan share the cost of covered services.** You pay coinsurance (a percentage of the cost) each time you get care. Your insurance covers the rest.

3. **You're protected by your plan's out-of-pocket limit.** That's the most you pay for covered health services each year.

    - Remember, this chart is only an example. Your actual costs will depend on the type of plan you choose, the service you get and the doctor. To see your actual costs, please refer to your plan information.

# Now, let's get started!

## Choose a health plan that works for you

You have three plan options to choose from. All plans give access to the BCBS large statewide network, cover preventive care services 100% in the network, and give you the financial protection and health care support you desire.

**Step 1 — Choose the plan that works for you.**
(Remember, if you have questions, call 404-636-7553)

**Step 2— Complete an open enrollment form and fax the form to 404-634-6099.**
(Print open enrollment forms from www.MyGDIS.com)

## Call GDIS

Call the GDIS dedicated insurance customer care team at 404-636-7553 if you need any assistance with choosing a plan.

# 2016 GDA health plans and rates
# plan name: POS 1000

| Open Access Network | In-Network | Out-of-Network |
|---|---|---|
| **Deductible** | | |
| You | $1,000 | $2,000 |
| You + Spouse | $2,000 | $4,000 |
| You + Child(ren) | $2,000 | $4,000 |
| You + Family | $2,000 | $4,000 |
| **Office Visit** | | |
| In Network Primary | $40 per visit | |
| In Network Specialist | $50 per visit | |
| Non Network | Deductible applies until met, then pays at 50% | |
| **Co-Insurance** | | |
| In Network | 70% of covered charges | |
| Non Network | 50% of covered charges | |
| **Inpatient Services** | | |
| In Network | $250 co-payment; deductible applies until met, then pays 70% | |
| Non Network | Deductible applies until met, then pays at 50% | |
| **Outpatient Services** | | |
| In Network | Deductible applies until met, then pays at 70% | |
| Non Network | Deductible applies until met, then pays at 50% | |
| Emergency Room | $250 co-payment | |
| **Prescription Card - *Select Rx Formulary** | | |
| Annual Deductible | $250 per person | |
| Tier 1 | $10 co-payment | |
| Tier 2 | $45 co-payment after $250 met | |
| Tier 3 | $80 co-payment after $250 met | |
| Tier 4 | 20% co-payment up to $200 maximum. | |
| **Out of Pocket** | | |
| You | $6,600 | $6,600 |
| You + Spouse | $13,200 | $13,200 |
| You + Child(ren) | $13,200 | $13,200 |
| You + Family | $13,200 | $13,200 |

| | Rates | Vision incl. |
|---|---|---|
| Employee | $594.08 | $599.85 |
| Employee + Spouse | $1,363.90 | $1,374.00 |
| Employee + Child(ren) | $1,263.83 | $1,274.79 |
| Family | $2,033.66 | $2,050.38 |

**Plan Highlights**

This plan offers a $40 co-payment when visiting a network primary care doctor. In-network hospital stay, outpatient visits, surgery and other major services from in-network providers are subject to the $1,000 calendar year deductible (max 2 per family) and are payable at 70% co-insurance.

Inpatient hospital visits require a $250 co-payment before the deductible and coinsurance. You may go to any provider in the BCBS Open Access POS (OAPOS) network.

Treatment from an out-of-network provider is subject to a $2,000 calendar year deductible (max 2 per family) and 50% co-insurance. Treatment from an in-network provider is subject to a $1,000 calendar year deductible (max 2 per family) and 70% co-insurance.

Once you pay your deductible(s) and reach $6,600 (max 2 per family) in covered eligible expenses, the plan pays any remaining covered eligible expenses at 100% in-network.

This plan also has a $250 Emergency Room co-payment. If admitted the co-payment is waived.

* Open Access means no referrals from a primary care physician. You can go direct to any specialist without a referral.

* $10,000 of term life insurance is provided for all employees under age 65 at a premium cost of $1.90 per employee per month. Rates listed include the $1.90.

* While the Select RX drug list is limited, it contains medications for every therapeutic class. Insureds should consult with their doctor to ensure that they prescribe a medication that is on the Select RX formulary. Directions on how to obtain the most current Select RX drug list is located in the back of the open enrollment packet.

**Find the summary of benefits and coverage for this plan starting on page 22.**

# 2016 GDA health plans and rates
# plan name: POS 2000

| Open Access Network | In-Network | Out-of-Network |
|---|---|---|
| **Deductible** | | |
| You | $2,000 | $3,500 |
| You + Spouse | $4,000 | $7,000 |
| You + Child(ren) | $4,000 | $7,000 |
| You + Family | $4,000 | $7,000 |
| **Office Visit** | | |
| In Network Primary | $40 per visit | |
| In Network Specialist | $50 per visit | |
| Non Network | Deductible applies until met, then pays at 50% | |
| **Co-Insurance** | | |
| In Network | 70% of covered charges | |
| Non Network | 50% of covered charges | |
| **Inpatient Services** | | |
| In Network | $250 co-payment; deductible applies until met then pays 70% | |
| Non Network | Deductible applies until met, then pays at 50% | |
| **Outpatient Services** | | |
| In Network | Deductible applies until met, then pays at 70% | |
| Non Network | Deductible applies until met, then pays at 50% | |
| Emergency Room | $250 co-payment | |
| **Prescription Card - * Select Rx Formulary** | | |
| Annual Deductible | $250 per person | |
| Tier 1 | $10 co-payment | |
| Tier 2 | $45 co-payment after $250 met | |
| Tier 3 | $80 co-payment after $250 met | |
| Tier 4 | 20% co-payment up to $200 maximum. | |
| **Out of Pocket** | | |
| You | $6,600 | $6,600 |
| You + Spouse | $13,200 | $13,200 |
| You + Child(ren) | $13,200 | $13,200 |
| You + Family | $13,200 | $13,200 |

| | Rates | Vision incl. |
|---|---|---|
| Employee | $573.67 | $579.44 |
| Employee + Spouse | $1,316.99 | $1,327.08 |
| Employee + Child(ren) | $1,220.36 | $1,231.32 |
| Family | $1,963.66 | $1,980.39 |

**Plan Highlights**

This plan offers a $40 co-payment when visiting a network primary care doctor. In-network hospital stay, outpatient visits, surgery and other major services from in-network providers are subject to the $2,000 calendar year deductible (max 2 per family) and are payable at 70% co-insurance.

Inpatient hospital visits require a $250 co-payment before the deductible and coinsurance. You may go to any provider in the BCBS Open Access POS (OAPOS) network.

Treatment from an out-of-network provider is subject to a $3,500 calendar year deductible (max 2 per family) and 50% co-insurance. Treatment from an in-network provider is subject to a $2,000 calendar year deductible (max 2 per family) and 70% co-insurance.

Once you pay your deductible(s) and reach $6,600 (max 2 per family) in covered eligible expenses, the plan pays any remaining covered eligible expenses at 100% in-network.

This plan also has a $250 Emergency Room co-payment. If admitted the co-payment is waived.

* Open Access means no referrals from a primary care physician. You can go direct to any specialist without a referral.

* $10,000 of term life insurance is provided for all employees under age 65 at a premium cost of $1.90 per employee per month. Rates listed include the $1.90.

* While the Select RX drug list is limited, it contains medications for every therapeutic class. Insureds should consult with their doctor to ensure that they prescribe a medication that is on the Select RX formulary. Directions on how to obtain the most current Select RX drug list is located in the back of the open enrollment packet.

**Find the summary of benefits and coverage for this plan starting on page 32.**

# 2016 GDA health plans and rates
# plan name: POS LOW

| Open Access Network | In Network | Out-of-Network |
|---|---|---|
| **Deductible** | | |
| You | $1,000 | $2,000 |
| You + Spouse | $2,000 | $4,000 |
| You + Child(ren) | $2,000 | $4,000 |
| You + Family | $2,000 | $4,000 |
| **Office Visit** | | |
| In Network Primary | $30 per visit | |
| In Network Specialist | $30 per visit | |
| Non Network | Deductible applies until met, then pays at 60% | |
| **Co-Insurance** | | |
| In Network | 80% of covered charges | |
| Non Network | 60% of covered charges | |
| **Inpatient Services** | | |
| In Network | $200 co-payment; deductible applies until met, then pays at 80% | |
| Non Network | $200 co-payment; deductible applies until met, then pays at 60% | |
| **Outpatient Services** | | |
| In Network | Deductible applies until met, then pays at 80% | |
| Non Network | Deductible applies until met, then pays at 60% | |
| Emergency Room | $100 co-payment | |
| **Prescription Card - Blue Choice Formulary** | | |
| Annual Deductible | $200 per person | |
| Tier 1 | $15 co-payment | |
| Tier 2 | $45 co-payment after $200 met | |
| Tier 3 | $60 co-payment after $200 met | |
| Tier 4 | 20% co-payment up to $200 maximum | |
| **Out of Pocket** | | |
| You | $2,500 | $5,000 |
| You + Spouse | $5,000 | $10,000 |
| You + Child(ren) | $5,000 | $10,000 |
| You + Family | $5,000 | $10,000 |

| | Rates | Vision incl. |
|---|---|---|
| Employee | $788.23 | $794.00 |
| Employee + Spouse | $1,810.46 | $1,820.55 |
| Employee + Child(ren) | $1,676.78 | $1,687.75 |
| Family | $2,699.02 | $2,715.74 |

**Plan Highlights**

This plan offers a $30 co-payment when visiting a network primary care doctor. In-network hospital stays; outpatient visits, surgery and other major services from in-network providers are subject to a $1,000 calendar year deductible (max of 2 per family) and are paid at 80% co-insurance.

Inpatient hospital visits require a $200 co-payment before the deductible and coinsurance. You may go to any provider in the BCBS Open Access POS (OAPOS) network.

Treatment from an in-network provider is subject to a $1,000 calendar year deductible (max 2 per family) and 80% co-payment. Treatment from an out-of-network provider is subject to a $2,000 calendar year deductible (max 2 per family) and 60% co-payment.

Once you pay your deductible(s) and reach $2,500 (max of 2 per family) in covered eligible expenses, the plan pays any remaining covered eligible expenses at 100% in-network.

Emergency room treatment requires a $100 co-payment. If admitted the co-payment is waived.

* Open Access means no referrals from a primary care physician. You can go direct to any specialist without a referral.

* $10,000 of term life insurance is provided for all employees under age 65 at a premium cost of $1.90 per employee per month. Rates listed include the $1.90.

**Find the summary of benefits and coverage for this plan starting on page 42.**

# Required annual notices

### Women's Health and Cancer Rights Act of 1998

In keeping with the Women's Health and Cancer Rights Act of 1998, a federal law, we would like to remind you of your rights regarding benefits for mastectomy-related services. Your contract includes benefits for certain services or supplies that relate to reconstructive surgery in connection with a mastectomy. (Mastectomy is surgical removal of a breast.) The covered service and supplies are listed here.

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and rebuilding of the other breast for a symmetrical appearance.
- Prostheses and physical complications at all stages of mastectomy.
- This includes services related to treating swollen lymph glands.

These benefits are subject to annual deductibles and coinsurance that apply to your contract. Please review your Contract of Group Service Agreement for more details about these benefits and your coverage in general.

### Statement of Rights under the Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child less than 48 hours following vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay in excess of 48 hours (or 96 hours).

### The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Georgia Dental Association has taken the appropriate steps to bring its health plans into compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule as of April 14, 2004. The Company is committed to protecting the medical and other personal health information of its enrollees.

Georgia Dental Association will not create or receive protected health information as defined in the HIPAA Privacy Rule except for summary health information and enrollment information.
In addition, Georgia Dental Association will not retaliate if an enrollee feels that their rights have been violated under the HIPAA Privacy Rule. No enrollee will be required to waive the privacy rights granted to them under HIPAA.

The Company's insurance carriers provide enrollees with a Notice of Privacy Practices as required under the HIPAA Privacy Rule.

### The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself and your dependents in a benefit plan offered by your employer in the future.

You have special enrollment rights if you or your dependent becomes eligible for the optional state premium assistance program if available in your state.

### Paul Wellstone and Pete Domenici Mental Health Parity and Addition Equality Act of 2008

All group health plans (exempting small employers) that provide medical and surgical benefits and mental health or substance abuse disorder benefits will be required to comply with the following requirements:

The financial requirement applicable to mental health or substance abuse disorders benefits are more restrictive than the predominant financial requirements applied to the substantially all medical and surgical benefits covered by the plan.

The treatment limitations applicable to mental health or substance abuse disorder benefits are more restrictive than the predominant treatment limitation supplied to substantially all medical and surgical benefits covered by the plan.

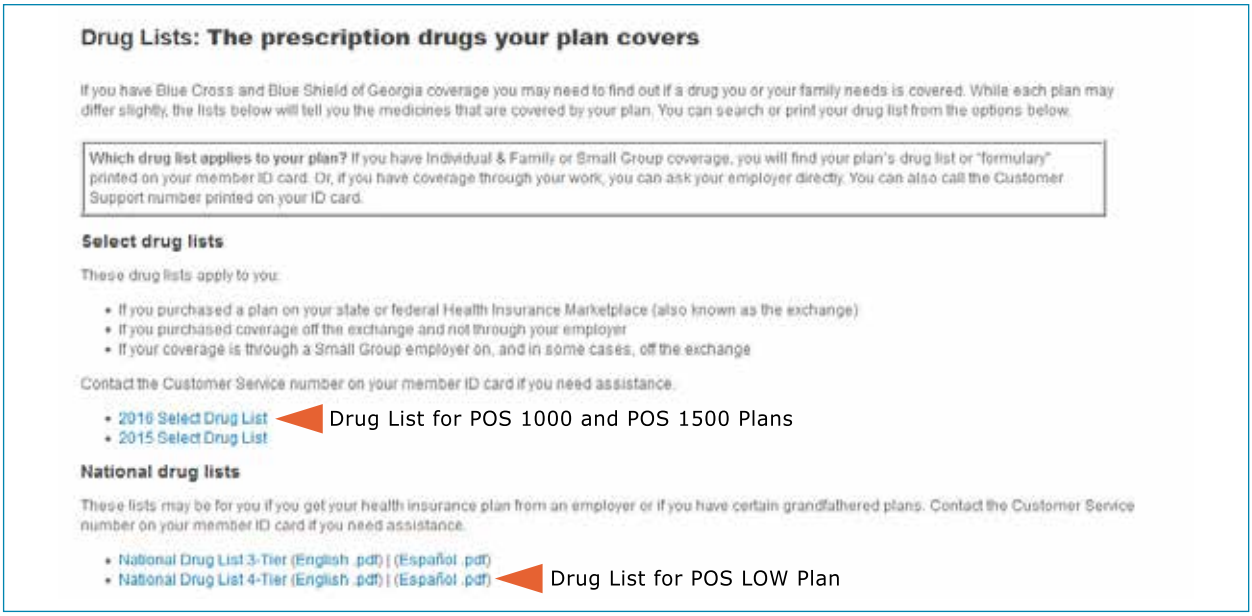
There can be no separate cost sharing requirements or treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

# 2016 Rx list for enrollees

## How to find drugs covered by your plan

It is easy to find a list of prescription drugs covered by your plan. Visit the BCBSGA website at www.bcbsga.com, then click on the "Resources tab" at the top of the page. Or, you can go directly to the link https://www.bcbsga.com/pharmacyinformation. Once you reach the pharmacy page, choose:

- **For the POS LOW plan, select the "National Drug List 4-Tier" PDF.**
- **For the POS 1000 and POS 2000 plans, select the "2016 Select Drug List" PDF.**

# Select drug list and 4-tier formulary

### Anthem Blue Cross and Blue Shield Select Drug List

Your prescription drug benefit includes coverage for medicines that you'll find on the Select Drug List. You can often find more savings when your doctor prescribes medicine that is on our Select Drug List. Here are some commonly asked questions and answers about how the Select Drug List works with your prescription drug plan.

**Q. What is a Select Drug List?**

A. The Select Drug List, also called a formulary is a list of U.S. Food and Drug Administration (FDA)-approved brand-name and generic drugs that have been reviewed and recommended for their quality and how well they work. The review is done by the National Pharmacy and Therapeutics (P&T) Process. The P&T Process is performed by an independent group of practicing doctors and pharmacists in charge of the research and decisions surrounding our Select Drug List. This group meets regularly to review new and existing drugs and they choose the top drugs for our list—based on their safety, how they work and their value.

Because the drugs on our list are reviewed from time to time, it's a good idea to check the list to find out if any drugs have been added or removed. You can do this by going to anthem.com.

**Q. What are Tiers?**

A. Drugs on the Select Drug List are grouped into tiers. There are several factors that are used to determine under which tier a drug will be put in. This can include (but it's not limited to):

- Cost of the drug
- Cost of the drug in comparison to other drugs used for the same type of treatment
- Availability of over-the-counter options
- Other clinical and cost factors.

**Q. What is a brand-name drug?**

A. These are drugs that are developed by a company who holds the rights to sell them. When the rights expire, other drug companies can make their own version of the drugs (see generic drugs below). You may be more familiar with brand-name drugs through advertising or because you know people who take them.

**Q. What is a generic drug?**

A. Generics are simply copies of brand-name drugs. Brand-name and generic drugs have the same active ingredients, strength and dose. And the FDA requires that generic drugs meet the same high standards for purity, quality, safety and strength.

**Q. What if my medication is not on the Select Drug List?**

A. You may want to first check with your doctor about prescribing a drug that is on the Select Drug List. If your doctor prescribes a drug that's not on the Select Drug List, you will have to pay the amount described in your policy for non-formulary drugs.

**Q. Can I request that a drug be added to the Select Drug List?**

A. You or your doctor can put in a request to add a drug to the Select Drug List. You can do this either in writing or on our website. Requests are reviewed by the P&T Process team during the Select Drug List review. **Please note that if a drug request is approved, it does not guarantee coverage. Some drugs, such as those used for cosmetic purposes, may be excluded from your benefits. Please refer to your insurance Certificate or Evidence of Coverage to know for sure.**

**Preventive Care Drugs:** We cover preventive care drugs with zero cost share in compliance with the Affordable Care Act (ACA).

**Please note:** In selecting medications for the prescription drug list, the therapeutic efficacy and cost effectiveness are addressed for each category. All therapeutic categories are represented on the drug list by at least one medication. When a closed drug list is in effect, only medications that are included on the drug list are a covered service. In certain clinical situations, a member may require use of a non-covered product. Anthem has criteria that permits a member to obtain a non-covered medication in a closed drug list plan. If specific criteria are met, a member can receive a non-covered drug for a drug list co-pay. The criteria preserves the clinical integrity of the drug list and provides a process by which deviations from the drug list may be allowed. An appeals process is in place for any medications that do not meet the criteria.

**Please note that completing the open enrollment form or waiver located on page 19 of this booklet is REQUIRED for every person in the office. Failure to complete and return an open enrollment form may result in plan termination.**

# 2016 Open Enrollment Form

Endorsed by GDA

**For individual coverage effective January 1, 2016**

Please **FAX** completed form to: **(404) 634-6099** or mail to: GDIS, 7000 Peachtree Dunwoody Rd NE, Suite 200, Building 17, Atlanta GA 30328-1655.

**All Employees MUST complete an enrollment form or coverage is subject to termination.**

## Part I: General Information - Please Print Legibly

| Name of Dentist/Employer | | | GDIS Group ID # |
|---|---|---|---|
| **(Applicant)** Last Name | First Name | | Middle Initial |
| **(Applicant)** Mailing address | | | |
| City | State | Zip Code | Hire Date |
| Home phone no. ( ) | Business phone no. ( ) | Email | |

## Part 2: Medical Coverage - Please select your choice:

☐ **ENROLL** (Complete parts 2a, 3 & 4) ☐ **CANCEL** - **Effective Date:** _____ (Sign & date below)
**(Date must be last day of month)**

☐ **WAIVE** coverage (Must state reason for waiver. Sign & date below)

**Reason for Waiver:** _____

## Part 2a: Medical Coverage - Please select your plan:

**Select ONE of the following plans below:**

☐ POS Low Plan ☐ POS 1000 Plan (w/ Select Rx) ☐ POS 2000 Plan (w/Select Rx)

## Part 2b: Vision Coverage - Blue View Vision (Optional Coverage)

☐ Blue View Vision Plan

## Part 3: Applicant and Covered Dependent Information

| | Add | Drop | Name (Last, First MI) | Social Security Number | Date of Birth mm/dd/yyyy | Male | Female |
|---|---|---|---|---|---|---|---|
| **Applicant** | | | | | | | |
| **Spouse** | | | | | | | |
| **Child** | | | | | | | |
| **Child** | | | | | | | |
| **Child** | | | | | | | |

## Part 4: Authorization (It is a Federal crime to knowingly provide false information on a medical coverage application)

**I REQUEST COVERAGE UNDER THIS GROUP PLAN. I have completed the information on this form. I understand that enrollment in this plan is subject to all the terms of the group plan, and that to be eligible, I must (a) be employed by the named employer in a class eligible for the coverage and (b) engaged in and perform the normal duties of such employment on a regular basis for at least the minimum number of hours per week (excluding duties performed at my residence or while confined in a hospital). I also understand that coverage will not become effective for me or any eligible dependent until all the applicable eligibility requirements of the group plan are met.**

- **I understand that coverage will not be effective unless I satisfy the conditions on this form.**
- **I understand that inaccurate answers to the questions on this enrollment form may void my coverage under this plan.**

**I hereby acknowledge that Blue Cross and Blue Shield of Georgia/Blue Cross Blue Shield Healthcare Plan of Georgia (BCBSGA/BCBSHP) has informed me of the following prior to my enrollment in their health care coverage plan:**
**a. number, mix and location of participating/network health care providers;**
**b. limitations on choices of participating/network health care providers;**
**c. disclosure of contractual relationship between participating/network provider and BCBSGA/BCBSHP.**

**Applicant's Signature** _____ **Date Signed** _____

## Expenses of plan administrator

**Expenses of Plan Administrator.** The Plan does not pay compensation to the Plan Administrator, Georgia Dental Insurance Services, Inc. The Plan reimburses the Plan Administrator for its direct expenses incurred in performing its duties on behalf of the Plan. Accordingly, Employee and Employer Contributions include a 6% administrative fee to cover such expenses. Expenses reimbursable to the Plan Administrator include, but are not limited to, fees of legal counsel, accountants and other specialists, plan communication and recordkeeping costs, plan audit fees, claims review and vendor searches. The 6% administrative fee and direct expenses are reconciled annually by an independent auditor and any excess portion of the fee above the amount of direct expenses actually incurred during each plan year is retained by the Plan.

## Summary of benefits and coverage

A "Summary of Benefits and Coverage" for each plan offered by Georgia Dental Insurance Services is located on pages 22-50. These are only summaries. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at https://eoc.bcbsga.com/eocdps/fi or by calling 1-855-397-9267.

# Blue Cross and Blue Shield of Georgia
# Georgia Dental Association: POS 1000

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period: 01/01/2016 – 12/31/2016**
**Coverage for:** Individual/Family | **Plan Type:** POS

**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at https://eoc.bcbsga.com/eocdps/fi or by calling 1-855-397-9267.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | For in-network providers<br>**$1,000** individual / **$2,000** family<br>For out-of-network providers<br>**$2,000** individual / **$4,000** family | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | Yes. For prescription drug drug tiers 2 and 3, the member must satisfy an annual deductible of **$250**. | In addition to the prescription drug **deductible,** please see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out–of–pocket limit on my expenses?** | Combined Medical and Rx:<br>For in-network providers<br>**$6,600** individual / **$13,200** family<br>For out-of-network providers<br>**$6,600** individual / **$13,200** family | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out–of–pocket limit?** | Premiums, balance-billed charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. For a list of **in-network providers**, see www.bcbsga.com<br>or call 1-855-397-9267 | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | No. You don't need a referral to see a specialist. | You can see the **specialist** you choose without permission from this plan. |

**Questions:** Call **1-855-397-9267** or visit us at **www.bcbsga.com**
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.bcbsga.com** or call **1-855-397-9267** to request a copy.

# Blue Cross and Blue Shield of Georgia
# Georgia Dental Association: POS 1000

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period: 01/01/2016 – 12/31/2016**

**Coverage for:** Individual/Family | **Plan Type:** POS

| | | |
|---|---|---|
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**. |

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | **$40** Copay/Visit | **50%** Coinsurance | ——————none—————— |
| | Specialist visit | **$50** Copay/Visit | **50%** Coinsurance | ——————none—————— |
| | Other practitioner office visit | **$50** Copay/Visit | **50%** Coinsurance | ——————none—————— |
| | Preventive care/screening/immunization | No Charge | **50%** Coinsurance | ——————none—————— |
| **If you have a test** | Diagnostic test (x-ray, blood work) | **30%** Coinsurance | **50%** Coinsurance | ——————none—————— |
| | Imaging (CT/PET scans, MRIs) | **30%** Coinsurance | **50%** Coinsurance | ——————none—————— |

# Blue Cross and Blue Shield of Georgia
# Georgia Dental Association: POS 1000

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period: 01/01/2016 – 12/31/2016**

**Coverage for:** Individual/Family | **Plan Type:** POS

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br><br>Please see your SelectRx formulary for more information about **prescription drug coverage**. | Tier 1 drugs | **$10** Copay retail/ **$20** Copay mail order | **$10** Copay retail/ **$20** Copay mail order | Retail and Specialty Pharmacy are 30 day supplies. Mail order is a 90 day supply.<br>A limited number of drugs require pre-authorization for medical necessity; please call Customer Service.<br>For out-of-network providers, the maximum allowance is based on the allowed fee for in-network providers. Members are held responsible for the balance between the billed charge and the amount allowed – plus deductibles and coinsurance. |
| | Tier 2 drugs | **$250** annual deductible, then **$45** Copay retail/ **$90** Copay mail order | **$250** annual deductible, then **$45** Copay retail/ **$90** Copay mail order | |
| | Tier 3 drugs | **$250** annual deductible, then **$80** Copay retail/ **$160** Copay mail order | **$250** annual deductible, then **$80** Copay retail/ **$160** Copay mail order | |
| | Tier 4 drugs | **20%** Copay up to **$200** maximum | **20%** Copay up to **$200** maximum | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | **30%** Coinsurance | **50%** Coinsurance | ——————none—————— |
| | Physician/surgeon fees | **30%** Coinsurance | **50%** Coinsurance | ——————none—————— |
| **If you need immediate medical attention** | Emergency room services | **$250** Copay/Visit | **$250** Copay/Visit | Copayment is waived if admitted. Non-emergency use is Not Covered. |
| | Emergency medical transportation | No Charge | No Charge | ——————none—————— |
| | Urgent care | **$60** Copay/Visit | **$60** Copay/Visit, then **50%** Coinsurance | ——————none—————— |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | **$250** Copay/Visit plus **30%** Coinsurance | **50%** Coinsurance | ——————none—————— |
| | Physician/surgeon fee | **30%** Coinsurance | **50%** Coinsurance | ——————none—————— |

# Blue Cross and Blue Shield of Georgia
# Georgia Dental Association: POS 1000

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period: 01/01/2016 – 12/31/2016**
**Coverage for:** Individual/Family | **Plan Type:** POS

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | **$40** Copay/Visit | **50%** Coinsurance | ——————none—————— |
| | Mental/Behavioral health inpatient services | **$250** Copay/Visit plus **30%** Coinsurance | **50%** Coinsurance | ——————none—————— |
| | Substance use disorder outpatient services | **$40** Copay/Visit | **50%** Coinsurance | ——————none—————— |
| | Substance use disorder inpatient services | **$250** Copay/Visit plus **30%** Coinsurance | **50%** Coinsurance | ——————none—————— |
| **If you are pregnant** | Prenatal and postnatal care | **$40** Copay/Visit, charged for first pre-natal visit only **30%** Coinsurance | **50%** Coinsurance | Costs are for Physician services only; facility copay and coinsurance will also apply. |
| | Delivery and all inpatient services | | **50%** Coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | **$40** Copay/Visit | **50%** Coinsurance | Limited to 120 visits per calendar year in-network and out-of-network combined. |

# Blue Cross and Blue Shield of Georgia
# Georgia Dental Association: POS 1000

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period: 01/01/2016 – 12/31/2016**

**Coverage for:** Individual/Family | **Plan Type:** POS

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Rehabilitation services | **$40** Copay/Visit | **50%** Coinsurance | In-network and out-of-network combined: Physical Therapy, Occupational Therapy, and Chiropractic Care limited to 30 combined visits per calendar year, Speech Therapy limited to 30 visits per calendar year. Services provided in a specialist office are subject to $50 copay, including Chiropractic Care. |
| | Habilitation services | **30%** Coinsurance | **50%** Coinsurance | All rehabilitation and habilitation visits count toward your rehabilitation visit limit. |
| | Skilled nursing care | **$250** Copay per admission, then **30%** Coinsurance | **50%** Coinsurance | Limited to 30 days per calendar year. |
| | Durable medical equipment | **30%** Coinsurance | **50%** Coinsurance | ——————none—————— |
| | Hospice service | No Charge | No Charge | ——————none—————— |
| **If your child needs dental or eye care** | Eye exam | Not Covered | Not Covered | ——————none—————— |
| | Glasses | Not Covered | Not Covered | ——————none—————— |
| | Dental check-up | Not Covered | Not Covered | ——————none—————— |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Coverage provided outside the United States. See www.BCBS.com/bluecardworldwide

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-397-9267. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Anthem BlueCross BlueShield
ATTN: Appeals
P.O. Box 105449
Atlanta, GA 30548-5449

Or Contact:

Department of Labor's Employee Benefits Security Administration at
1-866-444-EBSA(3272) or
www.dol.gov/ebsa/healthreform

Georgia Office of Insurance and Safety Fire Commissioner
Consumer Services Division
2 Martin Luther King, Jr. Drive
West Tower, Suite 716
Atlanta, Georgia 30334
(800) 656-2298
http://www.oci.ga.gov/ConsumerService/Home.aspx

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'alníhí ya sidáhí bich'į naabídíilkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,855
- **Patient pays** $1,685

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $1,000 |
| Copays | $130 |
| Coinsurance | $405 |
| Limits or exclusions | $150 |
| **Total** | **$1,685** |

### Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,744
- **Patient pays** $1,656

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $1000 |
| Copays | $390 |
| Coinsurance | $186 |
| Limits or exclusions | $80 |
| **Total** | **$1,656** |

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

# Blue Cross and Blue Shield of Georgia
# Georgia Dental Association: POS 2000

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period: 01/01/2016 – 12/31/2016**
**Coverage for:** Individual/Family | **Plan Type:** POS

**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at https://eoc.bcbsga.com/eocdps/fi or by calling 1-855-397-9267.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | For in-network providers<br>**$2,000** individual / **$4,000** family<br>For out-of-network providers<br>**$3,500** individual / **$7,000** family | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | Yes. For prescription drug drug tiers 2 and 3, the member must satisfy an annual deductible of **$250**. | In addition to the prescription drug **deductible,** please see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out–of–pocket limit on my expenses?** | Combined Medical and Rx:<br>For in-network providers<br>**$6,600** individual / **$13,200** family<br>For out-of-network providers<br>**$6,600** individual / **$13,200** family | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out–of–pocket limit?** | Premiums, balance-billed charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. For a list of **in-network providers**, see www.bcbsga.com<br>or call 1-855-397-9267 | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | No. You don't need a referral to see a specialist. | You can see the **specialist** you choose without permission from this plan. |

**Questions:** Call **1-855-397-9267** or visit us at **www.bcbsga.com**
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.bcbsga.com** or call **1-855-397-9267** to request a copy.

# Blue Cross and Blue Shield of Georgia
# Georgia Dental Association: POS 2000

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period: 01/01/2016 – 12/31/2016**
**Coverage for:** Individual/Family | **Plan Type:** POS

| | | |
|---|---|---|
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**. |

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | **$40** Copay | **50%** Coinsurance | ——————none—————— |
| | Specialist visit | **$50** Copay | **50%** Coinsurance | ——————none—————— |
| | Other practitioner office visit | **$50** Copay | **50%** Coinsurance | ——————none—————— |
| | Preventive care/screening/immunization | No Charge | **50%** Coinsurance | ——————none—————— |
| **If you have a test** | Diagnostic test (x-ray, blood work) | **30%** Coinsurance | **50%** Coinsurance | ——————none—————— |
| | Imaging (CT/PET scans, MRIs) | **30%** Coinsurance | **50%** Coinsurance | ——————none—————— |

# Blue Cross and Blue Shield of Georgia
# Georgia Dental Association: POS 2000

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period: 01/01/2016 – 12/31/2016**
**Coverage for:** Individual/Family | **Plan Type:** POS

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br><br>Please see your SelectRx formulary for more information about **prescription drug coverage**. | Tier 1 drugs | **$10** Copay retail/ **$20** Copay mail order | **$10** Copay retail/ **$20** Copay mail order | Retail and Specialty Pharmacy are 30 day supplies. Mail order is a 90 day supply.<br>A limited number of drugs require pre-authorization for medical necessity; please call Customer Service.<br>For out-of-network providers, the maximum allowance is based on the allowed fee for in-network providers. Members are held responsible for the balance between the billed charge and the amount allowed – plus deductibles and coinsurance. |
| | Tier 2 drugs | **$250** annual deductible, then **$45** Copay retail/ **$90** Copay mail order | **$250** annual deductible, then **$45** Copay retail/ **$90** Copay mail order | |
| | Tier 3 drugs | **$250** annual deductible, then **$80** Copay retail/ **$160** Copay mail order | **$250** annual deductible, then **$80** Copay retail/ **$160** Copay mail order | |
| | Tier 4 drugs | **20%** Copay up to **$200** maximum | **20%** Copay up to **$200** maximum | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | **30%** Coinsurance | **50%** Coinsurance | ——————none—————— |
| | Physician/surgeon fees | **30%** Coinsurance | **50%** Coinsurance | ——————none—————— |
| **If you need immediate medical attention** | Emergency room services | **$250** Copay/Visit | **$250** Copay/Visit | ——————none—————— |
| | Emergency medical transportation | No Charge | No Charge | ——————none—————— |
| | Urgent care | **$60** Copay/Visit | **$60** Copay/Visit, then **50%** Coinsurance | ——————none—————— |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | **$250** Copay/Visit plus **30%** Coinsurance | **50%** Coinsurance | ——————none—————— |
| | Physician/surgeon fee | **30%** Coinsurance | **50%** Coinsurance | ——————none—————— |

# Blue Cross and Blue Shield of Georgia
# Georgia Dental Association: POS 2000

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period: 01/01/2016 – 12/31/2016**

**Coverage for:** Individual/Family | **Plan Type:** POS

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | **$40** Copay/Visit | **50%** Coinsurance | ————————none———————— |
| | Mental/Behavioral health inpatient services | **$250** Copay/Visit plus **30%** Coinsurance | **50%** Coinsurance | ————————none———————— |
| | Substance use disorder outpatient services | **$40** Copay/Visit | **50%** Coinsurance | ————————none———————— |
| | Substance use disorder inpatient services | **$250** Copay/Visit plus **30%** Coinsurance | **50%** Coinsurance | ————————none———————— |
| **If you are pregnant** | Prenatal and postnatal care | **$40** Copay/Visit, charged for first pre-natal visit only | **50%** Coinsurance | Costs are for Physician services only; facility copay and coinsurance will also apply. |
| | Delivery and all inpatient services | **30%** Coinsurance | **50%** Coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | **30%** Coinsurance | **50%** Coinsurance | Limited to 120 visits per calendar year in-network and out-of-network combined. |
| | Rehabilitation services | **$40** Copay/Visit | **50%** Coinsurance | In-network and out-of-network combined: Physical Therapy, Occupational Therapy, and Chiropractic Care limited to 30 combined visits per calendar year, Speech Therapy limited to 30 visits per calendar year. Services provided in a specialist office are subject to $50 copay, including Chiropractic Care. |

# Blue Cross and Blue Shield of Georgia
# Georgia Dental Association: POS 2000

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period: 01/01/2016 – 12/31/2016**

**Coverage for:** Individual/Family | **Plan Type:** POS

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Habilitation services | **30%** Coinsurance | **50%** Coinsurance | All rehabilitation and habilitation visits count toward your rehabilitation visit limit. |
| | Skilled nursing care | **$250** Copay/Visit plus **30%** Coinsurance | **50%** Coinsurance | Limited to 30 days per calendar year. |
| | Durable medical equipment | **30%** Coinsurance | **50%** Coinsurance | ——————none—————— |
| | Hospice service | No Charge | No Charge | ——————none—————— |
| **If your child needs dental or eye care** | Eye exam | Not Covered | Not Covered | ——————none—————— |
| | Glasses | Not Covered | Not Covered | ——————none—————— |
| | Dental check-up | Not Covered | Not Covered | ——————none—————— |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Coverage provided outside the United States. See www.BCBS.com/bluecardworldwide

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-397-9267. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Anthem BlueCross BlueShield
ATTN: Appeals
P.O. Box 105449
Atlanta, GA 30548-5449

Or Contact:

Department of Labor's Employee Benefits Security Administration at
1-866-444-EBSA(3272) or
www.dol.gov/ebsa/healthreform

Georgia Office of Insurance and Safety Fire Commissioner
Consumer Services Division
2 Martin Luther King, Jr. Drive
West Tower, Suite 716
Atlanta, Georgia 30334
(800) 656-2298
http://www.oci.ga.gov/ConsumerService/Home.aspx

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíiłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,435
- **Patient pays** $3,105

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $2,000 |
| Copays | $40 |
| Coinsurance | $915 |
| Limits or exclusions | $150 |
| **Total** | **$3,105** |

### Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,710
- **Patient pays** $2,690

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $1,900 |
| Copays | $710 |
| Coinsurance | $0 |
| Limits or exclusions | $80 |
| **Total** | **$2,690** |

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

# Blue Cross and Blue Shield of Georgia
# Georgia Dental Association: POS LOW Option

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period: 01/01/2016 – 12/31/2016**
**Coverage for:** Individual/Family | **Plan Type:** POS

**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at https://eoc.bcbsga.com/eocdps/fi or by calling 1-855-397-9267.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | For in-network providers<br>**$1,000** individual / **$2,000** family<br>For out-of-network providers<br>**$2,000** individual / **$4,000** family | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | Yes. For prescription drug drug tiers 2 and 3, the member must satisfy an annual deductible of **$200**. | In addition to the prescription drug **deductible,** please see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out–of–pocket limit on my expenses?** | Combined Medical and Rx:<br>For in-network providers<br>**$2,500** individual / **$5,000** family<br>For out-of-network providers<br>**$5,000** individual / **$10,000** family | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out–of–pocket limit?** | Premiums, balance-billed charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. For a list of **in-network providers**, see www.bcbsga.com<br>or call 1-855-397-9267 | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | No. You don't need a referral to see a specialist. | You can see the **specialist** you choose without permission from this plan. |

**Questions:** Call **1-855-397-9267** or visit us at **www.bcbsga.com**
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.bcbsga.com** or call **1-855-397-9267** to request a copy.

# Blue Cross and Blue Shield of Georgia
# Georgia Dental Association: POS LOW Option

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period: 01/01/2016 – 12/31/2016**
**Coverage for:** Individual/Family | **Plan Type:** POS

| | | |
|---|---|---|
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**. |

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | **$30** Copay/Visit | **40%** Coinsurance | ——————none—————— |
| | Specialist visit | **$30** Copay/Visit | **40%** Coinsurance | ——————none—————— |
| | Other practitioner office visit | **$30** Copay/Visit | **40%** Coinsurance | ——————none—————— |
| | Preventive care/screening/immunization | No Charge | **40%** Coinsurance | ——————none—————— |
| **If you have a test** | Diagnostic test (x-ray, blood work) | **20%** Coinsurance | **40%** Coinsurance | ——————none—————— |
| | Imaging (CT/PET scans, MRIs) | **20%** Coinsurance | **40%** Coinsurance | ——————none—————— |

# Blue Cross and Blue Shield of Georgia
# Georgia Dental Association: POS LOW Option

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period: 01/01/2016 – 12/31/2016**

**Coverage for:** Individual/Family | **Plan Type:** POS

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.bcbsga.com | Tier 1 drugs | **$15** Copay retail/ **$30** Copay mail order | **$15** Copay retail/ **$30** Copay mail order | Retail and Specialty Pharmacy are 30 day supplies. Mail order is a 90 day supply.<br>A limited number of drugs require pre-authorization for medical necessity; please call Customer Service.<br>For out-of-network providers, the maximum allowance is based on the allowed fee for in-network providers. Members are held responsible for the balance between the billed charge and the amount allowed – plus deductibles and coinsurance. |
| | Tier 2 drugs | **$200** annual deductible, then **$45** Copay retail/ **$90** Copay mail order | **$200** annual deductible, then **$45** Copay retail/ **$90** Copay mail order | |
| | Tier 3 drugs | **$200** annual deductible, then **$60** Copay retail/ **$120** Copay mail order | **$200** annual deductible, then **$60** Copay retail/ **$120** Copay mail order | |
| | Tier 4 drugs | **20%** Copay up to **$200** maximum | **20%** Copay up to **$200** maximum | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | **20%** Coinsurance | **40%** Coinsurance | ——————none—————— |
| | Physician/surgeon fees | No Charge | **40%** Coinsurance | ——————none—————— |
| **If you need immediate medical attention** | Emergency room services | **$100** Copay/Visit | **$100** Copay/Visit | Copayment is waived if admitted. Non-emergency use is Not Covered. |
| | Emergency medical transportation | No Charge | No Charge | ——————none—————— |
| | Urgent care | **$60** Copay/Visit | **$60** Copay/Visit, then **40%** Coinsurance | ——————none—————— |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | **$200** Copay/Visit plus **20%** Coinsurance | **$200** Copay/Visit plus **40%** Coinsurance | ——————none—————— |
| | Physician/surgeon fee | No Charge | **40%** Coinsurance | ——————none—————— |

# Blue Cross and Blue Shield of Georgia
# Georgia Dental Association: POS LOW Option

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period: 01/01/2016 – 12/31/2016**

**Coverage for:** Individual/Family | **Plan Type:** POS

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | **$30** Copay/Visit | **40%** Coinsurance | ————————none———————— |
| | Mental/Behavioral health inpatient services | **$200** Copay/Visit plus **20%** Coinsurance | **$200** Copay/Visit plus **40%** Coinsurance | ————————none———————— |
| | Substance use disorder outpatient services | **$30** Copay/Visit | **40%** Coinsurance | ————————none———————— |
| | Substance use disorder inpatient services | **$200** Copay/Visit plus **20%** Coinsurance | **$200** Copay/Visit plus **40%** Coinsurance | ————————none———————— |
| **If you are pregnant** | Prenatal and postnatal care | **$30** Copay/Visit, charged for first pre-natal visit only | **40%** Coinsurance | Costs are for Physician services only; facility copay and coinsurance will also apply. |
| | Delivery and all inpatient services | | | |
| **If you need help recovering or have other special health needs** | Home health care | No Charge | **40%** Coinsurance | Limited to 120 visits per calendar year in-network and out-of-network combined. |
| | Rehabilitation services | **$30** Copay/Visit | **40%** Coinsurance | In-network and out-of-network combined: Physical Therapy, Occupational Therapy, and Chiropractic Care limited to 30 combined visits per calendar year, Speech Therapy limited to 30 visits per calendar year. |
| | Habilitation services | **$30** Copay/Visit | **40%** Coinsurance | All rehabilitation and habilitation visits count toward your rehabilitation visit limit. |

# Blue Cross and Blue Shield of Georgia
# Georgia Dental Association: POS LOW Option

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period: 01/01/2016 – 12/31/2016**
**Coverage for:** Individual/Family | **Plan Type:** POS

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Skilled nursing care | **$200** Copay per admission | **$200** Copay per admission, then **40%** Coinsurance | Limited to 30 days per calendar year. |
| | Durable medical equipment | **20%** Coinsurance | **40%** Coinsurance | ——————none—————— |
| | Hospice service | No Charge | No Charge | ——————none—————— |
| **If your child needs dental or eye care** | Eye exam | Not Covered | Not Covered | ——————none—————— |
| | Glasses | Not Covered | Not Covered | ——————none—————— |
| | Dental check-up | Not Covered | Not Covered | ——————none—————— |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

**Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Chiropractic care
- Coverage provided outside the United States. See www.BCBS.com/bluecardworldwide

**Questions:** Call **1-855-397-9267** or visit us at **www.bcbsga.com**
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## Your Rights to Continue Coverage:

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## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Anthem BlueCross BlueShield
ATTN: Appeals
P.O. Box 105449
Atlanta, GA 30548-5449

Or Contact:

Department of Labor's Employee Benefits
Security Administration at
1-866-444-EBSA(3272) or
www.dol.gov/ebsa/healthreform

Georgia Office of Insurance and Safety Fire Commissioner
Consumer Services Division
2 Martin Luther King, Jr. Drive
West Tower, Suite 716
Atlanta, Georgia 30334
(800) 656-2298
http://www.oci.ga.gov/ConsumerService/Home.aspx

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'alníhí ya sidáhí bich'į naabídíiłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

# Blue Cross and Blue Shield of Georgia
# Georgia Dental Association: POS LOW Option

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period: 01/01/2016 – 12/31/2016**
**Coverage for:** Individual/Family | **Plan Type:** POS

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

## Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,520
- **Patient pays** $2,020

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $1,000 |
| Copays | $60 |
| Coinsurance | $810 |
| Limits or exclusions | $150 |
| **Total** | **$2,020** |

## Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,426
- **Patient pays** $1,974

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $1,200 |
| Copays | $570 |
| Coinsurance | $124 |
| Limits or exclusions | $80 |
| **Total** | **$1,974** |

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

# You put your family first. So does your GDA.

When you're a GDA member, you're family. Let us create a health insurance plan that's right for you. Competitive rates, expanded coverage, and personalized options are just the beginning. GDA health coverage, where family comes first.

For additional information contact your Georgia Dental Insurance Services medical representative:

**Christy Biddy**
**Medical Insurance Benefits Coordinator**
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GDIS

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