2017 BENEFITS GUIDE

dental TLC sm .COM

Your 2017 Employee Benefits Guide

We recognize the important role employee benefits plays as a critical component of your overall compensation. Dental TLC continues to make every effort to target the best quality benefit plans for our employees and their families. We know that your benefits are important to you and your family, and this program is designed to assist you in providing for the health, well being, and financial security of you and your covered dependents. Helping you understand the benefits Dental TLC offers is important to us and that is why we have created this Employee Benefits Guide.

Benefits Guide Overview

This Guide, along with your Benefit Summaries, provides a full explanation of the benefits available to you and your family. At this time, all full time employees who work at least 30 hours per week are eligible for benefits and you may elect to enroll in the benefit programs offered. Options selected during this enrollment period will remain in place until 2017 Open Enrollment unless you or your dependents experience a qualified life event (see box below).

Changing Benefits During the Year

The IRS states that eligible employees may only make plan elections during their initial eligibility period or once a year at open enrollment. The initial eligibility period for Dental TLC is the first of the month after 60 days of employment. The following circumstances are the only reasons you may change your benefit elections during the year:

Marriage	**Death of a Dependent**
Divorce	**Dependent/Spouse Loss of Coverage**
Birth or Adoption	**Loss of Dependent Eligibility**
Change in Employment Status, Addition of a New Benefits Package, and Open Enrollment for a Spouse	

These special circumstances, often referred to as life event changes, allow you to make plan changes at any time during the year when they occur. You must inform Human Resources within 30 days of the event in order to make a qualified change. All other changes will be deferred to open enrollment.

Blue Open Access HMO – Large Groups
Plan OAH5 500/90 A Benefit Summary

All benefits are subject to the calendar year deductible, except those with in-network copayments, unless otherwise noted.
In addition to copayments, members are responsible for deductibles and any applicable coinsurance.
Members are also responsible for all costs over the plan maximums.
Some services may require pre-certification before services are covered by the Plan.

Deductibles, Coinsurance and Maximums	In-Network Benefit Level
Calendar Year Deductible*	
▪ Individual	$500
▪ Family	$1,500
Coinsurance	Member pays 10% Plan pays 90%
Calendar Year Out-of-Pocket Maximum*	
(includes calendar year deductible)	
▪ Individual	$2,000
▪ Family	$6,000
Lifetime Maximum	Unlimited

*Deductibles and out-of-pocket maximums are added separately for in-network and out-of-network services. One family member may reach his or her Individual deductible and be eligible for coverage on health care expenses before other family members. Each family member's deductible amount also goes toward the Family deductible and out-of-pocket maximum. Not everyone has to meet his or her deductible and out-of-pocket maximum for the family to meet theirs. When the Family deductible is met, all family members can access coverage for health care expenses.
The following do not apply to out-of-pocket maximums: non-covered items and any member cost shares for pharmacy services. The medical copayments on this plan will apply toward the out-of-pocket maximums.

Covered Services	In-Network Benefit Level
Preventive Care Services for Children and Adults (preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits)	
▪ Well-child care, immunizations ▪ Periodic health examinations ▪ Annual gynecology examinations ▪ Prostate screenings	Member pays 0% (not subject to deductible)
Physician Office Visits for Illness and Injury (including labs, x-rays and diagnostic procedures)	
▪ Primary Care Physician (PCP)*	$25 copayment
▪ OB/GYN	$25 copayment
▪ Specialist Physician	$50 copayment
*Also applies to services rendered at Retail Health Clinics	
Maternity Physician Services	
▪ 1st Prenatal visit	$25 copayment
▪ Global obstetrical care (prenatal, delivery and postpartum services)	Member pays 10% after deductible
Telemedicine Services	$25 PCP copayment or $50 Specialist copayment
Allergy Services	
▪ Office visits, testing and the administration of allergy injections	$25 PCP copayment or $50 Specialist copayment
▪ Allergy injection serum	Member pays 10% after deductible
Office Surgery (surgery and administration of general anesthesia)	Member pays 10% after deductible

Covered Services	In-Network Benefit Level
Office Therapy Services ▪ Physical Therapy and Occupational Therapy: 20-visit benefit period maximum combined ▪ Speech Therapy: 20-visit benefit period maximum ▪ Chiropractic Care/Manipulation Therapy: 20-visit benefit period maximum	$25 copayment
Other Therapy Services (chemotherapy, radiation therapy, cardiac rehabilitation [There is no Cardiac Rehabilitation visit max on this plan; EHB benchmark plan indicates zero max; authorization required] and respiratory/pulmonary therapy)	Member pays 10% after deductible
Advanced Diagnostic Imaging (MRI, MRA, CT Scans and PET Scans)	Member pays 10% after deductible
Urgent Care Center	$60 copayment
Emergency Room Services ▪ Life-threatening illness or serious accidental injury only ▪ The ER copayment will be waived if admitted to the hospital	$150 copayment; then member pays 10%
Outpatient Facility Services ▪ Surgery facility/hospital charges ▪ Diagnostic x-ray and lab services ▪ Physician services (anesthesiologist, radiologist, pathologist)	Member pays 10% after deductible
Inpatient Facility Services ▪ Daily room, board and general nursing care at semi-private room rate, ICU/CCU charges; other medically necessary hospital charges such as diagnostic x-ray and lab services; newborn nursery care ▪ Physician services (anesthesiologist, radiologist, pathologist)	Member pays 10% after deductible
Skilled Nursing Facility ▪ 30-day benefit period maximum	Member pays 10% after deductible
Mental Health/Substance Abuse Services (*services must be authorized by calling 1-800-292-2879)	
▪ Inpatient mental health and substance abuse services* (facility and physician fee)	Member pays 10% after deductible
▪ Partial Hospitalization Program (PHP) and Intensive Outpatient Program (IOP)* (facility and physician fee)	Member pays 10% after deductible
▪ Office/Outpatient mental health and substance abuse services (physician fee)	$25 copayment
Home Health Care Services ▪ 120-visit benefit period maximum	$25 copayment
Hospice Care Services ▪ Inpatient and outpatient services covered under the hospice treatment program	Member pays 0% (not subject to deductible)
Durable Medical Equipment (DME)	Member pays 10% after deductible
Ambulance Services ▪ Covered when medically necessary	Member pays 10% after deductible

Prescription Drugs (Option A)

Note: If a member receives a brand name drug that falls on Tier 2 or Tier 3 that has a generic equivalent available, the member pays the Tier 1 copay, plus the difference in cost between the brand drug and generic drug. This applies even when physician indicates DAW (dispense as written) or obtains an authorization.

Retail and Home Delivery maintenance drug coverage is provided at one of four tier levels in accordance with the Formulary Drug List. Members must file a claim form for reimbursement when using an out-of-network pharmacy.

Specialty drugs can only be obtained from a Specialty Pharmacy.

Refer to last page for Tier definitions

▪ Retail Drugs - Tier 1 (30 day supply)	$15 copayment
▪ Retail Drugs - Tier 2 (30 day supply)	$35 copayment
▪ Retail Drugs - Tier 3 (30 day supply)	$60 copayment
▪ Retail Drugs - Tier 4 (Specialty Drugs) (30 day supply)	Member pays 20%, up to a $200 maximum per prescription drug; $3,000 Rx out-of-pocket maximum per member per benefit period
▪ Home Delivery Maintenance Drugs - Tier 1 (90 day supply)	$15 copayment
▪ Home Delivery Maintenance Drugs - Tier 2 (90 day supply)	$70 copayment
▪ Home Delivery Maintenance Drugs - Tier 3 (90 day supply)	$180 copayment
▪ Home Delivery Maintenance Drugs - Tier 4 (Specialty Drugs) (30 day supply)	Member pays 20%, up to a $200 maximum per prescription drug; $3,000 Rx out-of-pocket maximum per member per benefit period

For a full disclosure of all benefits, exclusions and limitations please refer to your Certificate Booklet.

Prescription Drug Tier Definitions

Tier 1 – These drugs have the lowest copayment. This tier will contain low cost or preferred medications. This tier may include generic, single source brand drugs, or multi-source brand drugs.

Tier 2 – These drugs will have a higher copayment than tier 1 drugs. This tier will contain preferred medications that generally are moderate in cost. This tier may include generic, single source, or multi-source brand drugs.

Tier 3 – These drugs will have a higher copayment than tier 2 drugs. This tier will contain non-preferred or high cost medications. This tier may include generic, single source brand drugs, or multi-source brands drugs.

Tier 4 – Tier 4 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 3. This tier will contain Specialty Drugs.

Summary of Limitations and Exclusions

Your *Certificate Booklet* will provide you with complete benefit coverage information. Some key limitations and exclusions, however, are listed below:

- Routine physical examinations necessitated by employment, foreign travel or participation in school athletic programs
- Non-emergency use of the emergency room
- Removal/extraction of impacted teeth
- Private duty nursing
- Care or treatment that is not medically necessary
- Cosmetic surgery, except to restore function altered by disease or trauma
- Dental care and oral surgery; except for accidental injury to natural teeth, treatment of TMJ and radiation for head and neck cancer
- Occupational related illness or injury
- Treatment, drugs or supplies considered experimental or investigational

See Certificate Booklet for Complete Details

It is important to keep in mind that this material is a brief outline of benefits and covered services and is not a contract. Please refer to your *Certificate Booklet Form# HMO-LG, 01012014* (the contract) for a complete explanation of covered services, limitations and exclusions.

Open Access HMO Plan Design Number Legend
OAH = Open Access HMO
5 = copay and deductible/coinsurance benefit plans
A = Rx option A

Blue Open Access POS – Small and Large Groups
OAP5 1K/90 A Benefit Summary

All benefits are subject to the calendar year deductible, except those with in-network copayments, unless otherwise noted.
All calendar year maximums are combined between in-network and out-of-network.
In addition to copayments, members are responsible for deductibles and any applicable coinsurance.
Members are also responsible for all costs over the plan maximums.
Some services may require pre-certification before services are covered by the Plan.

When using out-of-network providers, members are responsible for any difference between the Maximum Allowed Amount and the amount the provider actually charges, as well as any copayments, deductibles and/or applicable coinsurance.

Deductibles, Coinsurance and Maximums	In-network Benefit Level	Out-of-Network Benefit Level
Calendar Year Deductible*		
▪ Individual	$1,000	$2,000
▪ Family	$3,000	$6,000
Coinsurance	Member pays 10% Plan pays 90%	Member pays 40% Plan pays 60%
Calendar Year Out-of-Pocket Maximum* (includes calendar year deductible)		
▪ Individual	$4,000	$8,000
▪ Family	$12,000	$24,000
Lifetime Maximum	Unlimited	Unlimited

*Deductibles and out-of-pocket maximums are added separately for in-network and out-of-network services. One family member may reach his or her Individual deductible and be eligible for coverage on health care expenses before other family members. Each family member's deductible amount also goes toward the Family deductible and out-of-pocket maximum. Not everyone has to meet his or her deductible and out-of-pocket maximum for the family to meet theirs. When the Family deductible is met, all family members can access coverage for health care expenses.
The following do not apply to out-of-pocket maximums: copayment amounts, non-covered items and any member cost shares for pharmacy services.

Covered Services	In-network Benefit Level	Out-of-Network Benefit Level
Preventive Care Services for Children and Adults (preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits) ▪ Well-child care, immunizations ▪ Periodic health examinations ▪ Annual gynecology examinations ▪ Prostate screenings	Member pays 0% (not subject to deductible)	Member pays 30% after deductible (deductible waived through age 5)
Physician Office Visits for Illness and Injury (including labs, x-rays, and diagnostic procedures)		
▪ Primary Care Physician (PCP)*	$25 copayment	Member pays 40% after deductible
▪ OB/GYN	$25 copayment	
▪ Specialist Physician	$50 copayment	
*Also applies to services rendered at Retail Health Clinics		
Maternity Physician Services		
▪ 1st Prenatal visit	$25 copayment	Member pays 40% after deductible
▪ Global obstetrical care (prenatal, delivery and postpartum services)	Member pays 10% after deductible	Member pays 40% after deductible
Telemedicine Services	$25 PCP copayment or $50 Specialist copayment	Member pays 40% after deductible
Allergy Services		
▪ Office visits, testing and the administration of allergy injections	$25 PCP copayment or $50 Specialist copayment	Member pays 40% after deductible
▪ Allergy injection serum	Member pays 10% after deductible	Member pays 40% after deductible

Covered Services	In-network Benefit Level	Out-of-Network Benefit Level
Office Surgery (surgery and administration of general anesthesia)	Member pays 10% after deductible	Member pays 40% after deductible
Office Therapy Services ▪ Physical Therapy and Occupational Therapy: 20-visit benefit period maximum combined ▪ Speech Therapy: 20-visit benefit period maximum ▪ Chiropractic Care/Manipulation Therapy: 20-visit benefit period maximum	$25 copayment	Member pays 40% after deductible
Other Therapy Services (chemotherapy, radiation therapy, cardiac rehabilitation [36-visit benefit period maximum] and respiratory/pulmonary therapy)	Member pays 10% after deductible	Member pays 40% after deductible
Advanced Diagnostic Imaging (MRI, MRA, CT Scans and PET Scans)	Member pays 10% after deductible	Member pays 40% after deductible
Urgent Care Services	$60 copayment	Member pays 40% after deductible
Emergency Room Services ▪ Life-threatening illness or serious accidental injury only ▪ The ER copayment will be waived if admitted to the hospital	$150 copayment; then member pays 10%	$150 copayment; then member pays 10%
Outpatient Facility Services ▪ Surgery facility/hospital charges ▪ Diagnostic x-ray and lab services ▪ Physician services (anesthesiologist, radiologist, pathologist)	Member pays 10% after deductible	Member pays 40% after deductible
Inpatient Facility Services ▪ Daily room, board and general nursing care at semi-private room rate, ICU/CCU charges; other medically necessary hospital charges such as diagnostic x-ray and lab services; newborn nursery care ▪ Physician services (anesthesiologist, radiologist, pathologist)	Member pays 10% after deductible	Member pays 40% after deductible
Skilled Nursing Facility ▪ 150-day benefit period maximum	Member pays 10% after deductible	Member pays 40% after deductible
Mental Health/Substance Abuse Services (*services must be authorized by calling 1-800-292-2879)		
▪ Inpatient mental health and substance abuse services* (facility and physician fee)	Member pays 10% after deductible	Member pays 40% after deductible
▪ Partial Hospitalization Program (PHP) and Intensive Outpatient Program (IOP)* (facility and physician fee)	Member pays 10% after deductible	Member pays 40% after deductible
▪ Office/Outpatient mental health and substance abuse services (physician fee)	$25 copayment	Member pays 40% after deductible
Home Health Care Services ▪100-visit benefit period maximum	$25 copayment	Member pays 40% after deductible
Hospice Care Services ▪ Inpatient and outpatient services covered under the hospice treatment program	Member pays 0% (not subject to deductible)	Member pays 30% after deductible
Durable Medical Equipment (DME)	Member pays 10% after deductible	Member pays 40% after deductible
Ambulance Services (covered when medically necessary)	Member pays 10% after deductible	Member pays 10% after deductible

Prescription Drugs (Option A) Note: If a member receives a brand name drug that falls on Tier 2 or Tier 3 that has a generic equivalent available, the member pays the Tier 1 copay, plus the difference in cost between the brand drug and generic drug. This applies even when physician indicates DAW (dispense as written) or obtains an authorization.	
Retail and Home Delivery maintenance drug coverage is provided at one of four tier levels in accordance with the Formulary Drug List. Members must file a claim form for reimbursement when using an out-of-network pharmacy. Specialty drugs can only be obtained from a Specialty Pharmacy. Refer to last page for Tier definitions	
▪ Retail Drugs - Tier 1 (30 day supply)	$15 copayment
▪ Retail Drugs - Tier 2 (30 day supply)	$35 copayment
▪ Retail Drugs - Tier 3 (30 day supply)	$60 copayment
▪ Retail Drugs - Tier 4 (Specialty Drugs) (30 day supply)	Member pays 20%, up to a $200 maximum per prescription drug; $3,000 Rx out-of-pocket maximum per member per benefit period
▪ Home Delivery Maintenance Drugs - Tier 1 (90 day supply)	$15 copayment
▪ Home Delivery Maintenance Drugs - Tier 2 (90 day supply)	$70 copayment
▪ Home Delivery Maintenance Drugs - Tier 3 (90 day supply)	$180 copayment
▪ Home Delivery Maintenance Drugs - Tier 4 (Specialty Drugs) (30 day supply)	Member pays 20%, up to a $200 maximum per prescription drug; $3,000 Rx out-of-pocket maximum per member per benefit period

For a full disclosure of all benefits, exclusions and limitations please refer to your Certificate Booklet.

Prescription Drug Tier Definitions

Tier 1 – These drugs have the lowest copayment. This tier will contain low cost or preferred medications. This tier may include generic, single source brand drugs, or multi-source brand drugs.

Tier 2 – These drugs will have a higher copayment than tier 1 drugs. This tier will contain preferred medications that generally are moderate in cost. This tier may include generic, single source, or multi-source brand drugs.

Tier 3 – These drugs will have a higher copayment than tier 2 drugs. This tier will contain non-preferred or high cost medications. This tier may include generic, single source brand drugs, or multi-source brands drugs.

Tier 4 – Tier 4 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 3. This tier will contain Specialty Drugs.

Pre-Existing Condition Limitation and Credit for Prior Coverage

For in-network services, there is no pre-existing condition limitation. For out-of-network services, benefits are not available during a pre-existing limitation period for services for any illness, injury or condition for which medical advice or treatment was recommended by, or received from, a health care provider within six months preceding the effective date of coverage. The pre-existing limitation period may be reduced or eliminated by the submission of a certificate of prior creditable coverage. The pre-existing limitation period does not apply to newborns, members under age 19, adoptions, placements for adoption or pregnancies.

Summary of Limitations and Exclusions

Your *Certificate Booklet* will provide you with complete benefit coverage information. Some key limitations and exclusions, however, are listed below:

- Routine physical examinations necessitated by employment, foreign travel or participation in school athletic programs
- Non-emergency use of the emergency room
- Removal/extraction of impacted teeth
- Private duty nursing
- Care or treatment that is not medically necessary
- Cosmetic surgery, except to restore function altered by disease or trauma
- Dental care and oral surgery; except for accidental injury to natural teeth, treatment of TMJ and radiation for head and neck cancer
- Occupational related illness or injury
- Treatment, drugs or supplies considered experimental or investigational
- Smoking cessation products

See Certificate Booklet for Complete Details

It is important to keep in mind that this material is a brief outline of benefits and covered services and is not a contract. Please refer to your *Certificate Booklet Form# WGAPOS-001, 01012012* (the contract) for a complete explanation of covered services, limitations and exclusions.

Open Access POS Plan Design Number Legend
OAP = Open Access POS
5 = copay and deductible/coinsurance benefit plans
A = Rx option A

BlueCross BlueShield Healthcare Plan of Georgia

The Power of Blue℠

Blue Open Access POS – Large Groups
OAP5 3.5K/80 A Benefit Summary

All benefits are subject to the calendar year deductible, except those with in-network copayments, unless otherwise noted.
All calendar year maximums are combined between in-network and out-of-network.
In addition to copayments, members are responsible for deductibles and any applicable coinsurance.
Members are also responsible for all costs over the plan maximums.
Some services may require pre-certification before services are covered by the Plan.

When using out-of-network providers, members are responsible for any difference between the Maximum Allowed Amount and the amount the provider actually charges, as well as any copayments, deductibles and/or applicable coinsurance.

Deductibles, Coinsurance and Maximums	In-network Benefit Level	Out-of-Network Benefit Level
Calendar Year Deductible*		
▪ Individual	$3,500	$7,000
▪ Family	$10,500	$21,000
Coinsurance	Member pays 20% Plan pays 80%	Member pays 40% Plan pays 60%
Calendar Year Out-of-Pocket Maximum* (includes calendar year deductible)		
▪ Individual	$6,350	$12,700
▪ Family	$12,700	$25,400
Lifetime Maximum	Unlimited	Unlimited

*Deductibles and out-of-pocket maximums are added separately for in-network and out-of-network services. One family member may reach his or her Individual deductible and be eligible for coverage on health care expenses before other family members. Each family member's deductible amount also goes toward the Family deductible and out-of-pocket maximum. Not everyone has to meet his or her deductible and out-of-pocket maximum for the family to meet theirs. When the Family deductible is met, all family members can access coverage for health care expenses.
The following do not apply to out-of-pocket maximums: non-covered items and any member cost shares for pharmacy services.

Covered Services	In-network Benefit Level	Out-of-Network Benefit Level
Preventive Care Services for Children and Adults (preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits) ▪ Well-child care, immunizations ▪ Periodic health examinations ▪ Annual gynecology examinations ▪ Prostate screenings	Member pays 0% (not subject to deductible)	Member pays 30% after deductible (deductible waived through age 5)
Physician Office Visits for Illness and Injury (including labs, x-rays, and diagnostic procedures)		
▪ Primary Care Physician (PCP)*	$25 copayment	Member pays 40% after deductible
▪ OB/GYN	$25 copayment	
▪ Specialist Physician	$50 copayment	
*Also applies to services rendered at Retail Health Clinics		
Maternity Physician Services		
▪ 1st Prenatal visit	$25 copayment	Member pays 40% after deductible
▪ Global obstetrical care (prenatal, delivery and postpartum services)	Member pays 20% after deductible	Member pays 40% after deductible
Telemedicine Services	$25 PCP copayment or $50 Specialist copayment	Member pays 40% after deductible
Allergy Services		
▪ Office visits, testing and the administration of allergy injections	$25 PCP copayment or $50 Specialist copayment	Member pays 40% after deductible
▪ Allergy injection serum	Member pays 20% after deductible	Member pays 40% after deductible

Covered Services	In-network Benefit Level	Out-of-Network Benefit Level
Office Surgery (surgery and administration of general anesthesia)	Member pays 20% after deductible	Member pays 40% after deductible
Office Therapy Services ▪ Physical Therapy and Occupational Therapy: 20-visit benefit period maximum combined ▪ Speech Therapy: 20-visit benefit period maximum ▪ Chiropractic Care/Manipulation Therapy: 20-visit benefit period maximum	$25 copayment	Member pays 40% after deductible
Other Therapy Services (chemotherapy, radiation therapy, cardiac rehabilitation [0-visit benefit period maximum; authorization required] and respiratory/pulmonary therapy)	Member pays 20% after deductible	Member pays 40% after deductible
Advanced Diagnostic Imaging (MRI, MRA, CT Scans and PET Scans)	Member pays 20% after deductible	Member pays 40% after deductible
Urgent Care Services	$60 copayment	Member pays 40% after deductible
Emergency Room Services ▪ Life-threatening illness or serious accidental injury only ▪ The ER copayment will be waived if admitted to the hospital	$150 copayment; then member pays 20%	$150 copayment; then member pays 20%
Outpatient Facility Services ▪ Surgery facility/hospital charges ▪ Diagnostic x-ray and lab services ▪ Physician services (anesthesiologist, radiologist, pathologist)	Member pays 20% after deductible	Member pays 40% after deductible
Inpatient Facility Services ▪ Daily room, board and general nursing care at semi-private room rate, ICU/CCU charges; other medically necessary hospital charges such as diagnostic x-ray and lab services; newborn nursery care ▪ Physician services (anesthesiologist, radiologist, pathologist)	Member pays 20% after deductible	Member pays 40% after deductible
Skilled Nursing Facility ▪ 30-day benefit period maximum	Member pays 20% after deductible	Member pays 40% after deductible
Mental Health/Substance Abuse Services (*services must be authorized by calling 1-800-292-2879)		
▪ Inpatient mental health and substance abuse services* (facility and physician fee)	Member pays 20% after deductible	Member pays 40% after deductible
▪ Partial Hospitalization Program (PHP) and Intensive Outpatient Program (IOP)* (facility and physician fee)	Member pays 20% after deductible	Member pays 40% after deductible
▪ Office/Outpatient mental health and substance abuse services (physician fee)	$25 copayment	Member pays 40% after deductible
Home Health Care Services ▪120-visit benefit period maximum	$25 copayment	Member pays 40% after deductible
Hospice Care Services ▪ Inpatient and outpatient services covered under the hospice treatment program	Member pays 0% (not subject to deductible)	Member pays 30% after deductible
Durable Medical Equipment (DME)	Member pays 20% after deductible	Member pays 40% after deductible
Ambulance Services (covered when medically necessary)	Member pays 20% after deductible	Member pays 20% after deductible

Prescription Drugs (Option A) Note: If a member receives a brand name drug that falls on Tier 2 or Tier 3 that has a generic equivalent available, the member pays the Tier 1 copay, plus the difference in cost between the brand drug and generic drug. This applies even when physician indicates DAW (dispense as written) or obtains an authorization.	
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▪ Retail Drugs - Tier 4 (Specialty Drugs) (30 day supply)	Member pays 20%, up to a $200 maximum per prescription drug; $3,000 Rx out-of-pocket maximum per member per benefit period
▪ Home Delivery Maintenance Drugs - Tier 1 (90 day supply)	$15 copayment
▪ Home Delivery Maintenance Drugs - Tier 2 (90 day supply)	$70 copayment
▪ Home Delivery Maintenance Drugs - Tier 3 (90 day supply)	$180 copayment
▪ Home Delivery Maintenance Drugs - Tier 4 (Specialty Drugs) (30 day supply)	Member pays 20%, up to a $200 maximum per prescription drug; $3,000 Rx out-of-pocket maximum per member per benefit period

For a full disclosure of all benefits, exclusions and limitations please refer to your Certificate Booklet.

Prescription Drug Tier Definitions

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Tier 2 **–** These drugs will have a higher copayment than tier 1 drugs. This tier will contain preferred medications that generally are moderate in cost. This tier may include generic, single source, or multi-source brand drugs.

Tier 3 **–** These drugs will have a higher copayment than tier 2 drugs. This tier will contain non-preferred or high cost medications. This tier may include generic, single source brand drugs, or multi-source brands drugs.

Tier 4 – Tier 4 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 3. This tier will contain Specialty Drugs.

Summary of Limitations and Exclusions

Your *Certificate Booklet* will provide you with complete benefit coverage information. Some key limitations and exclusions, however, are listed below:

- Routine physical examinations necessitated by employment, foreign travel or participation in school athletic programs
- Non-emergency use of the emergency room
- Removal/extraction of impacted teeth
- Private duty nursing
- Care or treatment that is not medically necessary
- Cosmetic surgery, except to restore function altered by disease or trauma
- Dental care and oral surgery; except for accidental injury to natural teeth, treatment of TMJ and radiation for head and neck cancer
- Occupational related illness or injury
- Treatment, drugs or supplies considered experimental or investigational
- Smoking cessation products

See Certificate Booklet for Complete Details

It is important to keep in mind that this material is a brief outline of benefits and covered services and is not a contract. Please refer to your *Certificate Booklet Form# POS-LG, 01012014* (the contract) for a complete explanation of covered services, limitations and exclusions.

Open Access POS Plan Design Number Legend
OAP = Open Access POS
5 = copay and deductible/coinsurance benefit plans
A = Rx option A

BlueCross BlueShield Healthcare Plan of Georgia

The Power of Blue℠

3350 Peachtree Road, NE • Atlanta, Georgia 30326 • 1-855-397-9267

02599GAMENBGA– eff 1/1/14

Anthem

HSA Option GHSA581 A - OAPOS

Lumenos with HSA and Gift Card Rewards Plan Summary

The Lumenos® with HSA plan is designed to empower you to take control of your health, as well as the dollars you spend on your health care. This plan gives you the benefits you would receive from a typical health plan, plus health care dollars to spend your way. And you can earn rewards for taking certain steps to improve your health.

Your Lumenos with HSA and Gift Card Rewards Plan

First - Use your HSA to pay for covered services:

Health Savings Account

With the Lumenos with Health Savings Account (HSA), you can **contribute pre-tax dollars to your HSA**. Others may also contribute dollars to your account. You can use these dollars to help meet your annual deductible responsibility. Unused dollars can be saved or invested and accumulate through retirement.

Contributions to Your HSA

For 2016, contributions can be made to your HSA up to the following:

$3,350 individual coverage
$6,750 family coverage
+$1,000 age 55 and over

Note: These limits apply to all combined contributions from any source, except rollover funds.

Plus - To help you stay healthy, use:

Preventive Care

100% coverage for Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.

Preventive Care

No deductions from the HSA or out-of-pocket costs for you as long as you receive your preventive care from a network provider. If you choose to go to an out-of-network provider, your out-of-network deductible or traditional health coverage benefits will apply.

Then -

Your Deductible

The deductible is the annual amount you pay **–** using your HSA or out-of-pocket – before you reach the traditional health coverage portion of the plan.

Annual Deductible Responsibility

Network Providers	Out-of-Network Providers
$5,000 individual coverage	$10,000 individual coverage
$10,000 family coverage	$20,000 family coverage

If needed -

Traditional Health Coverage

Similar to a PPO or HMO, after you meet your deductible, you pay coinsurance (a percentage of the provider's charges) or a copay when you visit a network provider. You'll pay more if you visit an out-of-network provider.

Traditional Health Coverage

After your deductible, the plan pays:

100% for network providers	70% for out-of-network providers
100% for network pharmacies*	100% for out-of-network pharmacies*

After your deductible, your coinsurance or copay responsibility is:

0% for network providers — 30% for out-of-network providers

Retail (30-day): Tier 1/2/3/4 - $15/$35/$60/20%[1] for network and out-of-network pharmacies

Home Delivery (90-day): Tier 1/2/3/4 - $15/$70/$180/20%[1] for network and out-of-network pharmacies

*Plan pays percentage after member tier copay/coinsurance.

[1]Tier 4 is specialty drugs. You pay 20%, up to a $200 maximum per prescription drug. Specialty drugs are only available in a 30-day supply for retail and home delivery.

Additional protection:

For your protection, the total amount you spend out of your pocket is limited. Once you spend that amount, the **plan pays 100% of the cost for covered services** for the remainder of the plan year.

Annual Out-of-Pocket Maximum

Network Providers	Out-of-Network Providers
$6,000 individual coverage	$20,000 individual coverage
$12,000 family coverage	$40,000 family coverage

Your annual out-of-pocket maximum consists of your annual deductible responsibility and your copay/coinsurance amounts.

Earn More Money for Your Account

What's special about your HSA plan is that you may earn rewards dollars to redeem for gift cards to select retailers. It's how your Lumenos plan rewards you for taking steps to improve your health.

Earn Rewards:

If you do this:	You can earn these rewards dollars for gift cards:
Complete the MyHealth Assessment online	$50
Enroll in a Health Coaching Program	$100
Graduate from a Health Coaching Program	$200
Complete our Healthy Lifestyles: Tobacco-Free Program	$50
Complete our Healthy Lifestyles: Healthy Weight Program	$50

Some eligibility requirements apply. See Page 2 for program descriptions.

If you have questions, please call toll-free 1-877-812-9777.

Lumenos with HSA and Gift Card Rewards Plan Summary

Earn Rewards

You can earn reward dollars to redeem for gift cards at select retailers. Earn gift card rewards for the following:

- **MyHealth Assessment:** You and your family members can complete the MyHealth Assessment, our online tool designed to help measure your overall health. One adult family member is eligible to earn a $50 gift card reward per plan year. The health information you provide is strictly confidential.
- **Health Coaching Programs:** If you qualify for one of our health coaching programs, you'll receive one-on-one assistance from a registered nurse to help you manage a health condition. Health conditions may include, but are not limited to, diabetes, asthma, high blood pressure, heart disease and pregnancy. You'll receive a $100 gift card reward for enrolling in a qualified program (one reward per covered person per year). You'll receive a $200 gift card reward for achieving your health goals and graduating from the program (one reward per covered person per year).
- **Tobacco-Free Program:** This program helps you manage withdrawal symptoms, identify triggers and learn new behaviors and skills to remain tobacco-free. Participation is open to you and your covered family members age 18 or older, and includes phone counseling support, online tools, and nicotine-replacement therapy coverage. You and your spouse are eligible to receive a $50 gift card reward (one reward per person per lifetime) for completing this program.
- **Healthy Weight Program:** Our Healthy Weight Program provides personalized online and phone support to help you adopt lifestyle changes necessary to lose weight and maintain weight loss. A team of trained health professionals with expertise in weight management will help you address healthy eating, physical activity and exercise, stress management, and more. You and your covered family members age 18 and older who have a Body Mass Index (BMI) of 25 or higher are eligible for this program. You and your spouse are eligible to receive a $50 gift card reward (one reward per person per lifetime) for completing this program.

Summary of Covered Services

Preventive Care

Anthem's Lumenos with HSA plan covers preventive services recommended by the U.S. Preventive Services Task Force, the American Cancer Society, the Advisory Committee on Immunization Practices and the American Academy of Pediatrics. The Preventive Care benefit includes screening tests, immunizations and counseling services designed to detect and treat medical conditions to help prevent avoidable premature injury, illness and death.

All preventive services received from a network provider are covered at 100%, are not deducted from your HSA and do not apply to your deductible. If you see an out-of-network provider, then your out-of-network deductible or out-of-network coinsurance responsibility will apply. If you receive any of these services for diagnostic purposes — for example, a colonoscopy when symptoms are present — the appropriate plan deductible and coinsurance will apply and available account dollars may be used to cover costs.

The following is an overview of the types of preventive services covered:

Child Preventive Care

Office Visits for preventive services
Screening Tests for vision, hearing, and lead exposure. Also includes pelvic exam and Pap test for females who are age 18, or have been sexually active.
Immunizations:
- Hepatitis A
- Hepatitis B
- Diphtheria, Tetanus, Pertussis (DtaP)
- Varicella (chicken pox)
- Influenza – flu shot
- Pneumococcal Conjugate (pneumonia)
- Human Papilloma Virus (HPV) – cervical cancer
- H. Influenza type b
- Polio
- Measles, Mumps, Rubella (MMR)

Adult Preventive Care

Office Visits for preventive services
Screening Tests for coronary artery disease, colorectal cancer, prostate cancer, diabetes, and osteoporosis. Also includes mammograms, as well as pelvic exams and Pap test.
Immunizations:
- Hepatitis A
- Hepatitis B
- Diphtheria, Tetanus, Pertussis (DtaP)
- Varicella (chicken pox)
- Influenza – flu shot
- Pneumococcal Conjugate (pneumonia)
- Human Papilloma Virus (HPV) – cervical cancer

If you have questions, please call toll-free 1-877-812-9777.

Lumenos with HSA and Gift Card Rewards Plan Summary

Summary of Covered Services (Continued)

Medical Care

Anthem's Lumenos with HSA plan covers a wide range of medical services to treat an illness or injury. You can use your available HSA funds to pay for these covered services. Once you spend up to your deductible amount shown on Page 1 for covered services, you will have traditional health coverage with the coinsurance listed on Page 1 to help pay for additional covered services.

The following is a summary of covered medical services under Anthem's Lumenos with HSA plan:

- Physician Office Visits
- Inpatient Hospital Services
- Outpatient Surgery Services
- Diagnostic X-rays/Lab Tests
- Emergency Hospital Services (network coinsurance applies to both network and out-of-network)
- Inpatient and Outpatient Mental Health and Substance Abuse Services
- Maternity Care
- Chiropractic Care
- Prescription Drugs
- Home Health Care and Hospice Care
- Physical, Speech, and Occupational Therapy Services
- Durable Medical Equipment

Some covered services may have limitations or other restrictions.* With Anthem's Lumenos with HSA plan, the following services are limited:

Skilled nursing facility limited to 150 days per benefit period.

Home health care services limited to 100 visits per benefit period.

Physical therapy and occupational therapy services limited to 20 visits per benefit period *(combined specialties)*.

Manipulation therapy services (chiropractic and osteopathic services) limited to 20 visits per benefit period.

Speech therapy services limited to 20 visits per benefit period.

Cardiac Rehabilitation services limited to 36 visits per benefit period.

Other Restrictions:
Specialty drugs can only be obtained from a Specialty Pharmacy.

Specific state mandates regarding limitations may apply.

*For a complete list of exclusions and limitations, please refer to your Certificate of Coverage. Some covered services may require pre-approval.

If you have questions, please call toll-free 1-877-812-9777.

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!

BlueCross BlueShield of Georgia

Blue View Vision℠ B6-10.25

Your Blue View Vision network

Blue Cross and Blue Shield of Georgia 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 copay	$42 allowance
Eyeglass frames Once every two calendar years you may select an eyeglass frame and receive an allowance toward the purchase price	$130 allowance, then 20% off any remaining balance	$45 allowance
Eyeglass lenses *(Standard)* Once every calendar year you may receive any one of the following lens options:		
• Standard plastic single vision lenses *(1 pair)*	$25 copay	$40 allowance
• Standard plastic bifocal lenses *(1 pair)*	$25 copay	$60 allowance
• Standard plastic trifocal lenses *(1 pair)*	$25 copay	$80 allowance
Eyeglass lens enhancements When obtaining covered eyewear from a Blue View Vision provider, you may choose to add any of the following lens enhancements at no extra cost.		
• Transitions® Lenses (for a child under age 19)	$0 copay	No allowance on lens enhancements when obtained out-of-network
• Standard Polycarbonate (for a child under age 19)	$0 copay	
• Factory Scratch Coating	$0 copay	
Contact lenses – once every calendar year		
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.		
• Elective Conventional Lenses; or	$130 allowance, then 15% off any remaining balance	$92 allowance
• Elective Disposable Lenses; or	$130 allowance *(no additional discount)*	$92 allowance
• Non-Elective Contact Lenses	Covered in full	$210 allowance

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

You may use your <u>in-network</u> benefit to order your contact lenses from 1-800 CONTACTS
1-800 CONTACTS offers a huge in-stock inventory, unbeatable prices, outstanding customer service and free shipping.
Just call 1-800 CONTACTS or go to 1800contacts.com for fast and easy ordering of your contact lenses.

EXCLUSIONS & LIMITATIONS (not a comprehensive list)

Combined Offers. Not to be combined with any offer, coupon, or in-store advertisement.
Excess Amounts. Amounts in excess of covered vision expense.
Sunglasses. Non-prescription sunglasses.
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 ONLY		In-network Member Cost (after any applicable copay)
Retinal Imaging - at member's option can be performed at time of eye exam		Not more than $39

Eyeglass lens upgrades
When obtaining eyewear from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies.
	• Transitions lenses (Adults)
	• Standard Polycarbonate (Adults)
	• Tint (Solid and Gradient)
	• UV Coating
	• Progressive Lenses[1]
	  ◦ Standard
	  ◦ Premium Tier 1
	  ◦ Premium Tier 2
	  ◦ Premium Tier 3
	• Anti-Reflective Coating[2]
	  ◦ Standard
	  ◦ Premium Tier 1
	  ◦ Premium Tier 2
	• Other Add-ons and Services
		$75
		$40
		$15
		$15
		
		$65
		$85
		$95
		$110
		
		$45
		$57
		$68
		20% off retail price

Additional Pairs of Eyeglasses Anytime from any Blue View Vision network provider.	• Complete Pair • Eyeglass materials purchased separately	40% off retail price 20% off retail price
Eyewear Accessories	• 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 A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.	• Standard contact lens fitting[3] • Premium contact lens fitting[4]	Up to $55 10% off retail price
Conventional Contact Lenses	• Discount applies to materials only	15% off retail price
SOME OF THE ADDITIONAL SAVINGS AVAILBLE THROUGH OUR SPECIAL OFFERS PROGRAM		
1-800 CONTACTS After your benefits for the coverage period have been used, you can save on contact lenses with this offer.[5]	• For this and other great offers, login to member services, select discounts, then Vision, Hearing & Dental	Save $20 on orders of $100 or more and get free shipping
Laser vision correction surgery LASIK refractive surgery.	• For this offer and more like it, login to member services, select discounts, then Vision, Hearing & Dental	Discount per eye

[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.

[5] Discount cannot be used in conjunction with your covered benefits.

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 by fax, email, or mail.

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.

Fax to: 866-293-7373
Email to: oonclaims@eyewearspecialoffers.com
Mail to: 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. Laws in some states may prohibit network providers from discounting products and services that are not covered benefits under the plan. 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.

Payroll Deduction Rates

BCBSGA POS OAP5 3.5K/80 A - Monthly Medical Deductions			
	Total Premium	**Employer Pays**	**Employee Pays**
Employee	$418.18	$418.18	$0.00
Employee & Spouse	$878.18	$418.18	$460.00
Employee & Child(ren)	$815.45	$418.18	$397.27
Family	$1,275.46	$418.18	$857.28

BCBSGA POS OAP5 1K/90 A - Monthly Medical Deductions			
	Total Premium	**Employer Pays**	**Employee Pays**
Employee	$570.24	$418.18	$152.06
Employee & Spouse	$1,197.50	$418.18	$779.32
Employee & Child(ren)	$1,111.96	$418.18	$693.78
Family	$1,739.22	$418.18	$1,321.04

BCBSGA HMO OAH5 500/90 A - Monthly Medical Deductions			
	Total Premium	**Employer Pays**	**Employee Pays**
Employee	$601.96	$418.18	$183.78
Employee & Spouse	$1,264.12	$418.18	$845.94
Employee & Child(ren)	$1,173.82	$418.18	$755.64
Family	$1,835.98	$418.18	$1,417.80

BCBSGA GHSA581M A - Monthly Medical Deductions			
	Total Premium	**Employer Pays**	**Employee Pays**
Employee	$394.53	$418.18	-$23.65
Employee & Spouse	$828.51	$418.18	$410.33
Employee & Child(ren)	$769.33	$418.18	$351.15
Family	$1,203.33	$418.18	$785.15

Blue Cross - Monthly Vision Deductions			
	Total Premium	**Employer Pays**	**Employee Pays**
Employee	$9.37	$0.00	$9.37
Employee & Spouse	$16.40	$0.00	$16.40
Employee & Child(ren)	$16.02	$0.00	$16.02
Family	$25.81	$0.00	$25.81

2016 Health Plan Notices

⋆ Michelle's Law

All group health plans must allow a college student with a "serious illness or injury" to remain eligible for active dependent coverage for 12 months, even if he or she no longer qualifies as a full-time student. The law applies to both insured and self-insured health plans.

The specific requirements are:

- The individual must be covered as a full-time student, as defined in the plan, at a postsecondary educational institution immediately before any serious illness or injury occurs.
- The student must experience a "serious illness or injury" that requires a medically necessary leave of absence or a medically necessary change in enrollment status from full-time to part-time. The term "serious illness or injury" is not defined.
- A physician must verify the illness or injury in writing and certify the leave of absence or change in enrollment status as medically necessary. The law does not contain a deadline by which this information must be provided.
- The health plan must allow the student to remain covered as an active participant/dependent for 12 months after the leave of absence begins. The regular premium will apply during these 12 months.

  The 12 months, however, does not extend coverage beyond another independent event that would end active/dependent status, such as the parent's termination of employment or the student exceeding the plan's age limit.

  • COBRA coverage would not be offered until after the 12-month special period has expired, unless the student returns to full-time status and remains eligible under other terms of the plan.

⋆ HIPAA Notice of Privacy Practices Reminder Notice

The HIPAA Privacy Rule was originally effective on April 14, 2003. This rule required health plans to send participants an initial notice of privacy practices and then reminders must be given once every three years. This memo is a reminder that if you would like to see or obtain another copy of the health plan's HIPAA Privacy Notice, please contact Human Resources.

⋆ Women's Health and Cancer Rights Act of 1998

"Did you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy – related services, including reconstruction and surgery to achieve symmetry between the breasts, prosthesis, and complications resulting from a mastectomy (including lymphedema").

Please call your plan administrator for more information. These benefits may be subject to annual deductibles, co-insurance provisions or copays that are appropriate and consistent with other benefits under your plan.

⋆ The Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008, also referred to as GINA, is a new federal law that protects Americans from being treated unfairly because of differences in their DNA that may

affect their health. The new law prevents discrimination from health insurers and employers. The President signed the act into federal law on May 21, 2008. The parts of the law relating to health insurers will take effect by May 2009, and those relating to employers will take effect by November 2009.

Who needs protection from genetic discrimination?

Everyone should care about the potential for genetic discrimination. Every person has dozens of DNA differences that could increase or decrease his or her chance of getting a disease such as diabetes, heart disease, cancer or Alzheimer's. It's important to remember that these DNA differences don't always mean someone will develop a disease, just that the risk to get the disease may be greater.

More and more tests are being developed to find DNA differences that affect our health. These tests (called genetic tests) will become a routine part of health care in the future. Health care providers will use information about each person's DNA to develop more individualized ways of detecting, treating and preventing disease. But unless this DNA information is protected, it could be used to discriminate against people.

Why was the law needed?

The law was needed to help ease concerns about discrimination that might keep some people from getting genetic tests that could benefit their health. The law also enables people to take part in research studies without fear that their DNA information might be used against them in health insurance or the workplace.

Important Notice from Dental TLC

Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Dental TLC and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **Dental TLC has determined that the prescription drug coverage offered by their group plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Dental TLC coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current Dental TLC coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Dental TLC and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Dental TLC changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

1. Visit www.medicare.gov
2. Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
3. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	October 18, 2016
Name of Entity/Sender:	Dental TLC
Contact--Position/Office:	Tiffany Vennie
Address:	290 Hilderbrand Dr A-9 Atlanta GA 30328
Phone Number:	404 255-2273

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Tiffany Vennie 404 255-2273.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
Dental TLC	
5. Employer address	6. Employer phone number
290 Hilderbrand Dr A-9	

7. City	8. State	9. ZIP code
Atlanta	GA	30328

10. Who can we contact about employee health coverage at this job?	
Tiffany Vennie	
11. Phone number (if different from above)	12. Email address
	tiffanyv@dentaltlc.com

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☒ All employees. Eligible employees are:

Full-time employees who work a minimum of 30 hours per week

☐ Some employees. Eligible employees are:

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

*Legal spouses

*Children up to age 26 to include: natural born children, step children, legally adopted children; grandchildren if employee has court ordered power of attorney. Handicapped dependent children are also eligible beyond age 26

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2015. Contact your State for more information on eligibility –

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
ALASKA – Medicaid	**INDIANA – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://www.in.gov/fssa Phone: 1-800-889-9949
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884

KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633	Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: www.ohhs.ri.gov Phone: 401-462-5300

SOUTH CAROLINA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-866-435-7414	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends and you fulfill other special enrollment requirements. (These requirements are set out in your Certificate of Coverage)

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

There is an additional enrollment period if an employee or dependent loses eligibility for Children's Health Insurance Program (CHIP), Medicaid or becomes eligible for CHIP for Medicaid premium assistance. The special enrollment allows children or their parents to have 60 days, rather than 30, to request enrollment.

Also, your health plan may not establish rules for eligibility (including continued eligibility) of an individual to enroll under the terms of the plan based on a health status-related factor.

Complete If You Are Declining Coverage For Yourself Or Any Dependent:

If you are declining coverage for yourself or for any of your eligible dependents, you must complete the following information if you want to preserve your rights of Special Enrollment as explained above. If you decline coverage for yourself, the reason is:

☐ **I have other coverage** ☐ **Another reason**

If you decline coverage for one or more eligible dependents, please give the dependent's name below and indicate the reason coverage is declined.

Name _____ ☐ Dependent has other coverage ☐ Another reason

Name _____ ☐ Dependent has other coverage ☐ Another reason

Name _____ ☐ Dependent has other coverage ☐ Another reason

Name _____ ☐ Dependent has other coverage ☐ Another reason

_____ _____

Employee Name – Please Print Employee Social Security Number

_____ _____/_____/_____

Employee Signature **Date**

CBIZ Benefits & Insurance Services

Disclaimer: This benefit summary highlights key features of Dental TLC benefits program and does not include all plan rules and details. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be any inconsistencies between this summary and the legal plan documents, the plan documents are the final authority. Dental TLC reserves the right to change or discontinue its benefit plans at any time without prior advance notice.