



PPO Dental Plans - About the plan

These voluntary plans were designed specifically for members of the **State Bar of Georgia (SBOG)**, their employees, and dependents. As a member of SBOG, you are part of a large group with buying power. Through this plan, you will enjoy quality coverage at competitive group rates. This plan is a great solution for individual members or small firms that do not have access to group voluntary dental or to members employed by large firms that do not offer a quality dental insurance solution. To enroll in this plan, you must be a present member of SBOG, or an employee of a present member of SBOG. Dependent coverage is available to lawful spouses, domestic partners, and unmarried dependent children under age 25.

As a dual option plan, you may choose between the lower cost **Network Choice PPO Option**, which is designed for members to receive care through an Ameritas PPO network provider, and the **Freedom Choice PPO Option**, which is an incentive based program that gives you the freedom to visit any licensed dentist.

PPO Plan Options - Dental Plan Summary

	Network Choice PPO Option	Freedom Choice PPO Option		
		Year 1	Year 2	Year 3
Coinsurance				
Type 1	100%	100%	100%	100%
Type 2	80%	70%	80%	90%
Type 3	50%	30%	40%	50%
Deductible	\$50/Calendar Year Type 2&3 Waived Type 1	\$50/Calendar Year Type 2&3 Waived Type 1		
Maximum (per person)	\$1,000 per calendar year No Family Maximum	\$1,000 per calendar year No Family Maximum		
Covered Fee Allowance	Contracted Fee	90 th U&C		
Dental Rewards*	Included	Included		
Waiting Period	6 months of Type 3	6 months on Type 3		
		Year 1 benefits begin the 1 st day of coverage. Year 2 benefits begin on the 1 st day of the 13 th month. Year 3 benefits begin on the 1 st day of the 25 th month.		

Orthodontia Summary

Allowance All Plan Designs: In Network, discounted fee. Out of Network, U&C.

Coinsurance	No ortho coverage	50%
Lifetime Max (per person)	N/A	\$1,000
Waiting Period	N/A	12 months
Coverage for Adults	N/A	Yes

Monthly Rates for 01/01/12 – 12/31/12

	Region 1	Region 2	Region 3	Region 1	Region 2	Region 3
Enrollee Only	\$27.32	\$29.32	\$32.72	\$34.16	\$35.84	\$40.84
Enrollee + Spouse	\$57.68	\$61.96	\$69.20	\$72.16	\$75.60	\$86.28
Enrollee + Child(ren)	\$59.92	\$64.68	\$72.48	\$85.92	\$90.20	\$102.96
Enrollee + Spouse & Child(ren)	\$90.28	\$97.32	\$108.96	\$123.92	\$129.96	\$148.40

Region 1 (ZIP codes starting with 304, 307, 310, 312, 318, and 319)

Region 2 (ZIP codes starting with 301, 302, 308, 309, 313, 314, 315, 316, 317 and 398)

Region 3 (ZIP codes starting with 300, 303, 305 and 306)

- Premiums do not include the one-time \$20.00 non-refundable processing fee due at the time of enrollment when selecting the Direct Annual Billing payment method. (Processing fee is waived when selecting Monthly Auto-pay or when enrolling with a business with 5 or more participants). Contact administrator for firm list billing options.
- Premiums are subject to change.



Sample Procedure Listing (Current Dental Terminology © American Dental Association.)

	Network Choice PPO Option	Freedom Choice PPO Option
Type 1 Procedure (Frequency)	<ul style="list-style-type: none"> • Routine Exam (1 in 6 months) • Bitewing X-rays (1 in 12 months) • Full Mouth/Panoramic X-rays (1 in 5 years) • Periapical X-rays • Cleaning (1 in 6 months) • Fluoride for Children 13 and under (1 per benefit period) 	<ul style="list-style-type: none"> • Routine Exam (1 in 6 months) • Bitewing X-rays (1 in 12 months) • Full Mouth/Panoramic X-rays (1 in 5 years) • Periapical X-rays • Cleaning (1 in 6 months) • Fluoride for Children 13 and under (1 per benefit period)
Type 2 Procedure (Frequency)	<ul style="list-style-type: none"> • Sealants (age 13 and under) • Restorative Amalgams • Restorative Composites • Endodontics (nonsurgical) • Periodontics (nonsurgical) • Denture Repair • Simple Extractions 	<ul style="list-style-type: none"> • Sealants (age 13 and under) • Restorative Amalgams • Restorative Composites • Endodontics (nonsurgical) • Periodontics (nonsurgical) • Denture Repair • Simple Extractions
Type 3 Procedure (Frequency)	<ul style="list-style-type: none"> • Space Maintainers • Onlays • Crowns (1 per tooth in 10 years) • Crown Repair • Endodontics (surgical) • Periodontics (surgical) • Implants • Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 10 years) • Complex Extractions • Anesthesia • Bleaching (cosmetic) 	<ul style="list-style-type: none"> • Space Maintainers • Onlays • Crowns (1 per tooth in 10 years) • Crown Repair • Endodontics (surgical) • Periodontics (surgical) • Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 10 years) • Complex Extractions • Anesthesia

Dental Rewards®

These plans include a valuable feature that allows qualifying plan members to carryover part of their unused annual maximum. A member earns Dental Rewards by submitting at least one claim for dental expenses incurred during the benefit year, while staying at or under the threshold amount for benefits received for that year. In addition, a person earning Dental Rewards who submits a claim for services received through the dental PPO network earns an extra reward, called the PPO Bonus. Members and their covered dependents may accumulate rewards up to the stated maximum carryover amount, and then use those rewards for any covered dental procedures subject to applicable coinsurance and plan provisions. If a plan member doesn't submit a dental claim during a benefit year, all accumulated rewards are lost. But he or she can begin earning rewards again the very next year.

Plan Threshold	\$500	Dental benefits received for the calendar year cannot exceed this amount
Annual Carryover	\$250	Dental Rewards amount is added to the following year's maximum
PPO Bonus	\$100	Additional amount awarded for seeing a PPO Provider
Maximum Carryover	\$1,000	Maximum possible accumulation for Dental Rewards and PPO bonus combined



In Network vs Out of Network

With this plan, you have the right to receive care from any licensed dentist in the United States. However, your out-of-pocket costs will almost always be lower if you choose an Ameritas PPO dentist. The Ameritas PPO network includes more than 65,000 dentist locations nationwide.

	Network Choice PPO Option	Freedom Choice PPO Option
Visiting an Ameritas PPO network provider (In Network)	<p>Ameritas PPO dentists agree to provide treatment to plan participants at contracted fees prearranged with Ameritas, which means that your out-of-pocket expense will usually be lower. Here's how PPO costs are actively managed:</p> <ul style="list-style-type: none"> • True managed care discounts. Our network fees are typically 25% below average charges, or 30-50% below the 90th percentile. • Discounted fees. Our fees are appropriate for each PPO ZIP code, they're not lumped together in broad ranges. This means reimbursement levels for participants and dentists are appropriate to costs in their area. • We offer discounted fees on virtually all covered procedures, not just a few of the more common ones. <p>Ameritas PPO dentists will file claim forms on your behalf and will accept payment directly from Ameritas. This means that you do not need to pay the entire bill and await reimbursement. Instead, you pay only your portion of the coinsurance (including deductible, if necessary) at the time of service.</p> <p>Go online to www.memberbenefits.com/SBOG to find the participating network dentists who are most convenient for you.</p>	<p>Ameritas PPO dentists agree to provide treatment to plan participants at contracted fees prearranged with Ameritas, which means that your out-of-pocket expense will usually be lower. Here's how PPO costs are actively managed:</p> <ul style="list-style-type: none"> • True managed care discounts. Our network fees are typically 25% below average charges, or 30-50% below the 90th percentile. • Discounted fees. Our fees are appropriate for each PPO ZIP code, they're not lumped together in broad ranges. This means reimbursement levels for participants and dentists are appropriate to costs in their area. • We offer discounted fees on virtually all covered procedures, not just a few of the more common ones. <p>Ameritas PPO dentists will file claim forms on your behalf and will accept payment directly from Ameritas. This means that you do not need to pay the entire bill and await reimbursement. Instead, you pay only your portion of the coinsurance (including deductible, if necessary) at the time of service.</p> <p>Go online to www.memberbenefits.com/SBOG to find the participating network dentists who are most convenient for you.</p>
Visiting a non-Ameritas PPO network provider (Out of Network)	<p style="text-align: center;">Network Choice PPO Option</p> <p>The Network Choice PPO Option is not recommended for members electing to receive the majority of their dental care from a non-Ameritas PPO dentist. When receiving treatment from an "out-of-network" dentist, this plan will pay the applicable coinsurance level based on the Maximum Allowable Charge (MAC) in your specific ZIP Code area. The dentist may balance bill you for all charges above the MAC allowance. (For example, if your dentist charges \$140 for a Type 1 procedure that has a coinsurance level of %100 and a MAC of \$100, you would be responsible for paying the additional \$40 to the dentist.)</p>	<p style="text-align: center;">Freedom Choice PPO Option</p> <p>When receiving treatment from an out-of-network dentist, this plan will pay the applicable coinsurance level based on the out-of-network plan allowance. The out-of-network plan allowance is 90th U&C.</p> <p>90th U&C means 9 out of 10 dentists in a specific ZIP Code area charge at or below the plan allowance for a procedure. We determine the Usual and Customary (U&C) allowance using information including data from Ingenix, a multicarrier compilation formerly derived by the Health Insurance Association of America (HIAA). Plan members are reimbursed based on the appropriate charges in the dentist's ZIP Code area. Ameritas reviews U&C allowances annually.</p>

Pretreatment

While we don't require a pretreatment authorization form for any procedure, we recommend them for any dental work you consider expensive. As a smart consumer, it's best for you to know your share of the cost up front. Simply ask your dentist to submit the information for a pretreatment estimate to our customer relations department. We'll inform both you and your dentist of the exact amount your insurance will cover and the amount that you will be responsible for. That way, there won't be any surprises once the work has been completed.

Questions? Contact the administrator at 1-800-282-8626.

This document is a highlight of plan benefits provided by Ameritas Life Insurance Corp. as selected by your association it is not a certificate of insurance and does not include exclusions and limitations. For exclusions and limitations, or a complete list of covered procedures, contact the plan administrator. As a group plan, this plan is subject to changes in carrier, network, plan benefits, and premium rates.



Optional Vision Insurance (only available when included with dental coverage)

You may choose between the lower cost **Vision Perfect Option** and the **Focus Option**. Both plans allow for you to visit any licensed provider. The Vision Perfect provides additional discounts through the EyeMed network whereas the Focus Option provides additional discounts through the VSP network of providers.

Vision Plan Options - Plan Summary

	Vision Perfect Option		Focus Vision Option	
	EyeMed Network	Out of Network	VSP Network	Out of Network
Annual Eye Exam	covers up to \$45	In the Vision Perfect Plan, covered benefits are the same whether you visit an in-network or an out-of-network provider.	100% covered	covers up to \$52
Single Vision Lenses	covers up to \$35		100% covered	covers up to \$55
Bifocal Lenses	covers up to \$50		100% covered	covers up to \$75
Trifocal Lenses	covers up to \$65		VSP Discount	covers up to \$95
Progressive Lenses	covers up to \$70		100% covered	N/A
Lenticular Lenses	covers up to \$70		100% covered	covers up to \$125
Frame	covers up to \$80		covers up to \$120	covers up to \$45
Contact Lenses	covers up to \$95	covers up to \$120	covers up to \$105	
Frequency Limits <i>(Exams/Lenses/Frames)</i>	12/12/24 Months		12/12/24 Months	
Annual Deductible	\$20 Exams/Materials		\$10 Exams/\$25 Materials	
Plan Highlights	<ul style="list-style-type: none"> ➤ Choose any eyecare provider. ➤ Members pay the eye doctor for all services, then submit a claim for reimbursement. ➤ Claims are reimbursed based on a schedule of benefits, so you know precisely how much is covered ahead of time. ➤ Includes an optional program with access to EyeMed providers who offer eye wear and services at reduced costs. 		<ul style="list-style-type: none"> ➤ Enjoy 20% off additional non-covered complete pairs of prescription glasses and sunglasses. ➤ For contacts, receive 15% off your contact lens fitting and follow-up. ➤ Get special pricing on lens options such as ultraviolet coating. For LASIK or PRK, save an average of 15% off the usual & customary price—or 5% off the promotional price—with VSP and a contracted laser surgery center. ➤ VSP provides up to \$120 toward a new frame. If the member chooses a frame exceeding this allowance, he/she will receive a 20% discount off the excess amount. 	

Monthly Rates for 01/01/12 – 12/31/12

	All Regions	All Regions
Enrollee Only	\$5.44	\$9.80
Enrollee + Spouse	\$11.72	\$21.16
Enrollee + Child(ren)	\$9.48	\$17.12
Enrollee + Family	\$15.76	\$28.48

- Premiums do not include the one-time \$20.00 non-refundable processing fee due at the time of enrollment when selecting the Direct Annual Billing payment method. (Processing fee is waived when selecting Monthly Auto-pay or when enrolling with a business with 5 or more participants). Contact administrator for firm list billing options.
- Premiums are subject to change.



Optional Vision Option - Our Fine Print

Vision Perfect Option	Focus Vision Option
<p>Covered Expenses will not include, and no benefits will be payable for, expenses incurred for:</p> <ol style="list-style-type: none"> 1. vision examinations more than once in any twelve-month period. 2. lenses more than once in any twelve-month period. 3. frames more than once in any twenty-four month period. 4. contact lenses more than once in any twelve-month period. When chosen, contact lenses shall be in lieu of any other lens or frame benefit during the twelve-month period. When lenses and frames are chosen, expenses for contact lenses are not covered expenses during the twelve-month period. 5. examinations performed or frames or lenses ordered before the insured was covered under the eye care expense benefits. 6. subject to extension of benefits, any examination performed or frame or lens ordered after the insured's coverage under the eye care expense benefits ceases. 7. sub-normal eye care aids; orthoptic or eye care training or any associated testing. 8. non-prescription lenses. 9. replacement or repair of lost or broken lenses or frames except at normal intervals. 10. any eye examination or corrective eyewear required by an employer as a condition of employment. 11. medical or surgical treatment of the eyes. 12. any service or supply not shown on the Schedule of Eye Care Procedures. 13. coated lenses; oversize lenses (exceeding 71mm); photo-gray lenses; polished edges; UV-400 coating and facets, and tints other than solid. 	<p>Covered Expenses will not include, and no benefits will be payable for, expenses incurred for:</p> <ol style="list-style-type: none"> 1. vision examinations more than once in any twelve-month period. 2. lenses more than once in any twelve-month period, and then only if replacement is deemed necessary by the provider. 3. frames more than once in any twenty-four month period, and then only if replacement is deemed necessary by the provider. 4. contact lenses more than once in any twelve-month period. When chosen, contact lenses shall be in lieu of any other lens or frame benefit during the twelve-month period. When lenses and frames are chosen, expenses for contact lenses are not covered expenses during the twelve-month period. 5. medically necessary contact lenses, except for the first \$105 of expense, when such lenses are purchased for any reason other than for the following conditions: <ol style="list-style-type: none"> a. following cataract surgery b. to correct extreme visual problems that cannot be corrected with spectacle lenses c. certain conditions of anisometropia d. keratoconus <p>Medically necessary contact lenses are limited to the plan allowance (100% covered in-network, \$210 out-of-network). Such payment is limited to once in any twelve-month period and is in lieu of lenses and frame benefits under this policy.</p> 6. orthoptics or eye care training and any associated testing. 7. plano lenses. 8. two pairs of glasses in lieu of bifocals. 9. lenses and frames which are lost or broken, except at the normal intervals when services are otherwise available. 10. medical or surgical treatment of the eyes. 11. services for which a claim is filed more than 180 days after completion of the service. 12. the following materials, over and above the covered expense for the basic material. These materials are cosmetic and the insured will be responsible for the cost of these materials. <ol style="list-style-type: none"> a. blended lenses b. oversize lenses c. photo chromatic lenses; tinted lenses except pink #1 and #2 13. progressive multi-focal lenses 14. the coating of the lens or lenses 15. the laminating of the lens or lenses 16. frames exceeding the maximum allowance selected by the policyholder.

Questions? Contact the administrator at 1-800-282-8626.

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1. COMPLETE ENROLLMENT FORM

Make sure to complete the form in its entirety. Monthly rates for available options are included in kit. Omissions and illegible print may delay issuance of coverage.

2. PAYMENT OPTIONS

Payment Option 1 - Monthly Auto Pay

If you elect to pay by Monthly Bank Draft (ACH), you do not need to send any premium. Upon approval of your enrollment form, we will automatically draft your account on a monthly basis. Make sure to complete the Authorization section and include a VOIDED check.

Payment Option 2 - Direct Annual Billing

If you elect this method, **please make check or money order written out to BPC Financial**, for the pro-premium required to pay your coverage through the end of the plan year (December 31st).

For example, if you are enrolling for the 7/1 enrollment date, you will need to submit 6 months premium plus the one-time \$20.00 Direct Billing fee. You will be invoiced on an annual basis thereafter.

*The \$20.00 Direct Billing fee is required for each primary enrollee that selects the Direct Billing payment method. The Direct Billing fee is waived when enrolling with a firm of 5 or more primary enrollees or when selecting Monthly Auto Pay. Contact administrator for Firm list billing options.

3. FAX OR MAIL FORMS TO:

You may use this form as a FAX COVER

Fax to: (904) 396-2091

Name: _____ Date: _____
Attn: Enrollment/Processing

Or Mail to:

Program Administrator
BPC Financial
7645 Gate Parkway, Suite 101
Jacksonville, FL 32256

IMPORTANT: All requirements must be received by BPC Financial no later than the last day of the month prior to your requested enrollment date. Please note that failure to include all necessary requirements and correct payment amount or voided check could result in a delay of your policy effective date. Upon approval you will receive written notification of your effective date along with your ID cards and instructions on how to view your Certificate of Insurance (COI). Make sure to review the COI carefully. Be sure to understand all of your rights and benefits under the plan. If you are not completely satisfied, please notify us immediately.

ANY QUESTIONS? CALL TOLL-FREE: 1-800-282-8626

1. INDICATE COVERAGE DESIRED

Desired Enrollment Date: January 1 April 1 July 1 October 1 (Please note, all requirements must be received prior to your selected quarterly enrollment date. Otherwise, your enrollment will automatically take place on the following quarterly enrollment date.)

Plan Options: Network Choice PPO Dental Freedom Choice PPO Dental Focus Vision Vision Perfect

2. PRIMARY ENROLLEE INFORMATION

VERY IMPORTANT - PLEASE PRINT LEGIBLY (Please leave one blank box between each word)

Name: SBOG Member
(Last, First, Middle) Employee

Mailing Address:
(Street Address)

Male Female

Social Security #: - - Date of Birth: / /
(Month) (Day) (Year)

Email Address: Phone #: () -
(Please include working email address. Your certificate will be emailed to this address.)

SBOG Member's #: Name of Employer:

3. DEPENDENT ENROLLEE INFORMATION

(To add additional dependents, please attach a separate sheet.)

Spouse: Date of Birth: / /
(Month) (Day) (Year)

Dependent: Date of Birth: / /
(Month) (Day) (Year)

Dependent: Date of Birth: / /
(Month) (Day) (Year)

Dependent: Date of Birth: / /
(Month) (Day) (Year)

4. PLEASE INDICATE YOUR PAYMENT METHOD

Monthly Auto-Pay. Include a VOID check and complete the Authorization below.

I hereby authorize BPC Financial to initiate debit entries and to initiate, if necessary, credit entries as adjustments for any debit entries in error to my Checking account and the Financial Institution named below to debit and/or credit the same account. BPC Financial will not be held responsible for a policy lapse or cancellation due to nonpayment if withdrawal is prepared and not honored for any reason and amount due is not paid. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.

This authority is to remain in full force and effective until BPC Financial and the Financial Institution have received written notice from me of its termination in such time and manner as to afford BPC Financial and the Financial Institution a reasonable opportunity to act on it.

Accountholder's Signature: Date Signed: Name of Financial Institution:

Direct Annual Billing. (Please make check or money order written out to BPC Financial for premium required to pay your coverage through the end of plan year (December 31st) plus the one-time \$20.00, non-refundable Direct Billing fee.)

5. READ CAREFULLY, THEN SIGN AND DATE

As a member of the State Bar of Georgia, or an employee of a member, I hereby apply for group insurance, for which I am eligible or may become eligible. I understand that I am enrolling as a participant in a group plan. The plan provider, premium rates, and plan benefits may change. I have read and understand the conditions and plan limitations as described in the enrollment kit. I understand that coverage is effective on the next quarterly enrollment date following approval of my enrollment form and receipt of my initial payment. To the best of my knowledge and belief, the information I've provided is complete and correct.

Primary Enrollee's Signature: Date Signed: