GEORGIA RETIRED EDUCATORS ASSOCIATION

Take a look at your GREA dental benefits...

Dental care is just as important to a lifetime of good health as your medical plan. But caring for your teeth, and making sure your loved ones have good oral health care, can be expensive. You can offset these expenses by taking advantage of the dental benefits offered through Ameritas.

Dental Benefits	
What the plan pays	*In-Network/Out-of-Network*
Type 1: Routine cleanings & routine oral exams	100%
Type 2: Fillings, crown repair, denture repair & x-rays	80%
Type 3: Root canals, gum disease, crowns, dentures, general anesthesia & oral surgery	50%
Maximum (per person)	$1,500 Per Calendar Year
Deductible	$75 Per Calendar Year $225 Family Maximum
Monthly Rates	
Member Only	**$55.32**
Member + One	**$110.77**
Member + Family	**$149.60**

Reimbursement percentages are based on the maximum plan allowance charges for services in your geographical area. All services are subject to limitations and exclusions. The master policy is governed by the laws of the state of Georgia. Rates are guaranteed through June 2021.

Using your dental benefits is pain free!

See any dentist. Your Ameritas dental plan allows you and your family members to receive care from any licensed dental provider, regardless if they are in- or out-of-network. You do not need to switch providers. Family members do not need to see the same dentist.

Save money. Dentists in the Ameritas network (referred to as PPO providers) have agreed to a contracted fee. They charge you 25-50% less than their regular rates. Many of them also offer discounted fees on non-covered dental services as allowed by state law. Out-of-network (non-PPO) providers have not agreed to offer PPO discounts and will charge you their regular rates. If the dentist's charges happen to be higher than the usual and customary allowance, the difference will be an out-of-pocket expense.

Know whats covered. As a smart consumer, it's best for you to know your share of the cost up front. For services over $200 we recommend you ask your dentist to request a pretreatment estimate from our customer relations department. You will receive a written response showing what Ameritas estimates your dental plan will pay, and the amount that you will be responsible for.

Ameritas
fulfilling life.

Ameritas Rewards

Each year you submit at least one dental claim and keep your total amount of benefits paid under $750, you qualify to carry over $250 in benefit dollars to the following year. The maximum you can ever carry over is $1,000.

Annual Benefit Threshold	$750
Annual Maximum Benefit	**$1,500**
Dental Rewards Carry Over	**+ $250**
Next Benefit Year's Annual Maximum Benefit + Ameritas Rewards	**= $1,750**

Questions? Ask a friendly customer care representative today.

Call toll-free: (877) 290-3164

GEORGIA RETIRED EDUCATORS ASSOCIATION

Your VSP Vision Plan

Vision Service Plan (VSP), gives you access to a vast, nationwide network of ophthalmologists and optometrists. Without coverage, an exam and prescription glasses can cost around $450 or more. Take a look below to see how you can save with VSP!

What the Plan Pays	At a VSP Choice Network Provider	At an Out-of-Network Provider
Annual Exam	Covered in full	Up to $45
Single Vision lenses	Covered in full	Up to $30
Bifocal Lenses	Covered in full	Up to $50
Trifocal Lenses	Covered in full	Up to $65
Progressive Lenses	Covered in full	Up to $50
Frames	$150 ($170 on featured frame)	Up to $70
Contacts (elective)	Up to $150	Up to $105
Contacts (medically necessary)	Covered in full	Up to $210

Your VSP co-pays: $15 for exams and $25 for materials. No co-pay for contact lenses.
Benefit Frequencies: You get an exam and lenses every 12 months. Frames are available every 24 months.

Monthly Rates	
Member	**$13.80**
Member + One	**$26.40**
Member + Family	**$29.34**

VSP Choice Network

You have the freedom to choose the provider who's right for you. Keep in mind, when you visit a VSP provider, your out-of-pocket expenses are lower and there are no claim forms to complete. Find a VSP doctor today by visiting ***www.grea.vspforme.com***.

VSP offers the nation's largest network of independent doctors. Choose your provider from over 92,000 access points and more than 5,000 retail locations including:

Walmart · COSTCO WHOLESALE · Visionworks · RxOptical · eyeconic

When you visit a VSP provider, not only do you enjoy convenience and service, you'll save more than if you see an out-of-network provider.

- **20%** off remaining frame balance
- **20-25%** off non-covered lens options such as UV coating & polycarbonate
- **20%** off non-covered complete prescription glasses
- **15%** off LASIK and PRK laser surgery retail price or
- **5%** off promotion price

Based on applicable laws, reduced costs may vary by doctor location.

VSP

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GREA Dental & Vision Enrollment Form

Here to help,

Protect your smile for years to come with the GREA Dental and Vision insurance plan, administered by AMBA. It's easier than ever to find the right plan to meet all your dental health needs while controlling your costs. Our team is dedicated to providing you with the information you need to make the right choice for you. Complete the application below, or for additional questions regarding dental or vision plans call (877) 290-3164.

Three Ways to Apply Today!

You can pay your premium via **credit card** by enrolling online or by phone.

Online
Enroll online at MyAMBAbenefits.info/GREA

By Phone
Call AMBA at 1.877.290.3164 to complete the enrollment process

By Mail
Complete the information below and return in the postage paid envelope provided

STEP 1: TELL US ABOUT YOURSELF

Full Name: _____ Address: _____ City/State/Zip: _____	Gender: ☐ Male ☐ Female	Date of Birth: ____/____/_____ MM DD YYYY	Social Security Number (Required):
Phone Number: (_____) _____ - _____	Email Address:	Have you had continuous Dental coverage for the past 12 months with less than a 60 day gap in coverage? ☐ Yes ☐ No	
If yes, Name of Your Carrier:	Effective Date:	Termination Date:	

STEP 2: SPOUSE OR DEPENDENT INFORMATION

First Name: _____ Last Name: _____	Gender: ☐ Male ☐ Female	Date of Birth: ____/____/_____ MM DD YYYY	Disabled: ☐ Yes ☐ No	Social Security # (Required):

STEP 3: SELECT YOUR COVERAGE

Dental	☐ Member Only $55.32	☐ Member +1 $110.77	☐ Family $149.60
Vision	☐ Member Only $13.80	☐ Member +1 $26.40	☐ Family $29.34

STEP 4: PAYMENT CHOICE *(YOU CAN PAY YOUR PREMIUM VIA CREDIT CARD BY ENROLLING ONLINE OR BY PHONE)*

☐ **Annual Payment:** Submit your application to begin coverage on the effective date. You will then receive an invoice for the $20 application fee and your premium balance (through the end of this plan year).

☐ **Convenient Monthly Bank Draft:** Include a VOIDED CHECK from the account you wish to pay from. Your initial premium and $20 application fee will be drafted on or after your effective date of coverage.

Authorization to honor drafts drawn by Association Member Benefits Advisors. I hereby authorize you to initiate debit entries on my account. This authority is to remain in effect until revoked by me in writing and until AMBA receives such notice. I agree that AMBA shall be fully protected in honoring such debit. Non-payment of insurance premium(s) results in the forfeiture of insurance. I authorize future increases and/or decreases in the cost of the plan(s) I selected to be automatically deducted without further authorization from me. NOTE: Bank drafts occur on the 2nd business day of each month.

▶ _____ _____

Your signature EXACTLY as it appears on your Bank Records | Date

Eff Date: _____ **ACH Date:** _____ **Entered:** _____ **MA:** _____ **R:** _____ **App ID:** OSD