Great Bay Oral Surgery
Associates PA
Center for Dental Implants
Facial Aesthetic & Reconstructive Surgery

2015 – 2016
EMPLOYEE RECEIPT of REQUIRED NOTIFICATIONS at INITIAL or OPEN ENROLLMENT

To prepare for open enrollment or at initial eligibility, health plan sponsors (employers) are required to communicate changes to their plan participants primarily due to the federal health care reform law, the Affordable Care Act (ACA).

The notices listed below must be provided to employees annually and/or upon initial enrollment at time of hire.

Anthem BCBS Health Plan SBC (Summary of Benefits and Coverage)
*Women's Health and Cancer Rights Act*Preventive Health Care Services*DOL Model Exchange Notice*
*Newborns' and Mothers' Health Protection Act*General Notice of COBRA Continuation Coverage Rights*
*Children's Health Insurance Program Reauthorization Act*Medicare Part D Prescription Drug Coverage*

Health Insurance Effective Date: December 1, 2015 to November 30, 2016

Instructions: Once you complete the information below, please email, fax or hand-deliver the completed form to your Human Resources dept. for placement in your personnel file.

Date: _____

Employee Name: _____

Acknowledgement: **Yes**, I received the required compliance documents ☐

Employee Signature: _____

cc: Human Resources Dept., employee file

LANDMARK BENEFITS

Great Bay Oral Surgery Associates PA

Center for Dental Implants
Facial Aesthetic & Reconstructive Surgery

Health Plan Effective Dates: December 1, 2015 through November 30, 2016

Open and Initial Enrollment – Required Documents and Notices to be Distributed to Employees

The following required notifications are included in or attached to this document:

- **Summary of Benefits and Coverage**, page 1-2 *(copy of SBC is attached)*
- **Women's Health and Cancer Rights Act**, page 2
- **Preventive Care Services**, page 2 *(copy of Preventive Care Services is attached)*
- **Department of Labor Model Exchange Notice**, page 3 *(copy of DOL Notice is attached)*
- **Newborns' and Mothers' Health Protection Act**, page 3
- **General Notice of COBRA Continuation Coverage Rights**, page 4 *(copy of COBRA Notice is attached)*
- **Children's Health Insurance Program Reauthorization Act**, page 4-5
- **Medicare Part D Prescription Drug Coverage**, page 5-6

For more information regarding your health plan please contact your company **Benefits Administrator**:
Pam Iverson (603) 692-6598

Summary of Benefits & Coverage of Health Insurance

Under the Affordable Care Act, health insurers and group health plans will provide the 180 million Americans who have private insurance with clear, consistent and comparable information about their health plan benefits and coverage.

Under the law, insurance companies and group health plans will provide consumers with a concise document detailing, in plain language, simple and consistent information about health plan benefits and coverage.

This summary of benefits and coverage document will help consumers better understand the coverage they have and, for the first time, allow them to easily compare different coverage options. It will summarize the key features of the plan or coverage, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions.

An SBC must be provided to all "participants and beneficiaries" without charge regardless of group size and/or the employee's intent to elect or waive benefits. Participants include employees or retirees who are, or may become, eligible for a benefit under the plan; beneficiaries include the participant's dependents that may be entitled to coverage under the plan.

SBCs should be provided at the following times:

- **Initial enrollment**: An SBC for each benefit package option for which the participant becomes eligible (e.g., new hires, qualifying status changes) must be included in any distribution of enrollment materials. If written enrollment materials are not distributed, the SBC must be furnished no later than the first date the individual is eligible to enroll in coverage.
- **Open enrollment**: An SBC for the benefit package option in which the participant is enrolled must be included with other open enrollment materials. The regulations provide that if reenrollment is automatic, the SBC must be provided no later than 30 days before the beginning of the next plan year.
- **HIPAA special enrollment**: Generally, an SBC for the benefit package option in which a special enrollee enrolls must be provided no later than 90 days after enrollment (the same time frame for providing an SPD). However, individuals who have not yet enrolled may request an SBC for any benefit package option at any time. These SBCs must be furnished as described below.
- **On request:** An SBC must be provided as soon as practical (but no more than seven business days) after a request.

Women's Health and Cancer Rights Act (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Refer to the attached **Anthem Blue Cross Blue Shield SBC (Summary of Benefits and Coverage)** for specific member cost share effective **December 1, 2015**.

Health Insurance Preventive Care Services Legislation

The Affordable Care Act – the health insurance reform legislation passed by Congress and signed into law by President Obama on March 23, 2010 – helps make prevention affordable and accessible for all Americans by requiring health plans to cover preventive services and by eliminating cost sharing for those services.

Preventive services that have strong scientific evidence of their health benefits must be covered and plans can no longer charge a patient a copayment, coinsurance or deductible for these services when they are delivered by a network provider.

Details on the specific preventive care services included, at no cost to members, through your **Anthem Blue Cross Blue Shield** health insurance plan are listed on the attached **Preventive Services** document.

Department of Labor Model Exchange Health Insurance Marketplace Notice

Beginning no later than October 1, 2013, group health plan sponsors (employers) must give a written notice to each employee (regardless of the employee's plan enrollment status, if applicable, or of part-time or full-time status), providing information about coverage options under the state and federal health benefits exchanges (referred to as "the Health Insurance Marketplace" or "Marketplace").

The notice deadline of October 1, 2013, is the date when "open enrollment" begins for coverage through the Marketplace.

For new employees, effective October 1, 2013, employers must provide the notice at the time of hiring.

For 2014, if the notice is provided within 14 days of the employee's start date, then the DOL will consider the notice to be provided at the time of hiring.

Newborns' and Mothers' Health Protection Act (NMHPA)

The Newborns' and Mothers' Health Protection Act of 1996 (the Newborns' Act), signed into law on September 26, 1996, requires plans that offer maternity coverage to pay for at least a 48-hour hospital stay following childbirth (96-hour stay in the case of a cesarean section).

This law was effective for group health plans for plan years beginning on or after January 1, 1998.

On October 27, 1998, the Department of Labor, in conjunction with the Departments of the Treasury and Health and Human Services, published interim regulations clarifying issues arising under the Newborns' Act. The changes made by the regulations are effective for group health plans for plan years beginning on or after January 1, 1999.

The Newborns' Act and its regulations provide that health plans and insurance issuers may not restrict a mother's or newborn's benefits for a hospital length of stay that is connected to childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending provider (who may be a physician or nurse midwife) may decide, after consulting with the mother, to discharge the mother or newborn child earlier.

The Newborns' Act, and its regulations, prohibits incentives (either positive or negative) that could encourage less than the minimum protections under the Act as described above.

A mother cannot be encouraged to accept less than the minimum protections available to her under the Newborns' Act and an attending provider cannot be induced to discharge a mother or newborn earlier than 48 or 96 hours after delivery.

The type of coverage provided by the plan (insured or self-insured) and state law will determine whether the Newborns' Act applies to a mother's or newborn's coverage.

The Newborns' Act provisions always apply to coverage that is self-insured. If the plan provides benefits for hospital stays in connection with childbirth and is insured, whether the plan is subject to the Newborns' Act depends on State law. Based on a recent preliminary review of State laws, if the coverage is in Wisconsin and several U.S. territories, it appears that the Federal Newborns' Act applies to the plan. If the coverage is in any other state or the District of Columbia, it appears that State law applies in lieu of the Federal Newborns' Act.

Continuation Coverage Rights Under COBRA

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the group health plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, please refer to the **attached Initial COBRA letter** and also, you should review the Plan's Summary Plan Description or contact the Benefit Administrator.

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

Maine, Massachusetts, Vermont and New Hampshire
Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

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, 2012. You should contact your State for further information on eligibility –

MAINE – Medicaid	**VERMONT**– Medicaid
Phone: 1-800-977-6740; **Website:** http://www.maine.gov/dhhs/ofi/public-assistance/index.html	**Phone:** 1-800-250-8427; **Website:** http://www.greenmountaincare.org/
MASSACHUSETTS – Medicaid and CHIP	**NEW HAMPSHIRE** – Medicaid
Phone: 1-800-462-1120; **Website:** http://www.mass.gov/eohhs/gov/departments/masshealth/	**Phone:** 603-271-5218; **Website:** http://www.dhhs.nh.gov/ombp/index.htm

*To view additional States that have added a premium assistance program since January 31, 2012, or for more information on special enrollment rights, you can contact either:

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

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

Medicare Part D Prescription Drug Coverage

Employees, their spouses and other dependents who will be or currently are 65 years old or older within the next year- *PLEASE READ*

If you or any of your dependents is Medicare Part D eligible and considering enrolling in the **Great Bay Oral Surgery** Prescription Drug Coverage, please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the **Great Bay Oral Surgery** 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. The **Bronze Craft Corporation** has determined that the prescription drug coverage offered by **Anthem Blue Cross Blue Shield** 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.

The information on the following page will help you better understand how and when you can join a Medicare Drug Plan if you so choose.

Medicare Part D Prescription Drug Coverage

Joining a Medicare Drug Plan-

You can join a Medicare drug plan when you first become eligible for Medicare and each year from OCTOBER 15th until 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.

Your Current Coverage and a Medicare Drug Plan-

If you decide to join a Medicare drug plan, your **Great Bay Oral Surgery** coverage will not be affected.

Please see your **Anthem Blue Cross Blue Shield SBC (Summary of Benefits and Coverage)** plan description for more detail to compare the plan provisions/options between your **Great Bay Oral Surgery** plan and the Medicare Part D coverage. You may also contact the Human Resources Department for more information and answers to your questions.

If you decide to join a Medicare drug plan and drop your **Great Bay Oral Surgery** coverage, be aware that you and your dependents may or may not be able to get this coverage back, see your **Anthem Blue Cross Blue Shield SBC (Summary of Benefits and Coverage)** plan description for verification or contact your Human Resources Department for more information.

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 **Great Bay Oral Surgery** 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.

Anthem BlueCross BlueShield
HMO Blue NE HMO HNEVP58VE $4000/$12000 / Rx $10/$35/30% H

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

Coverage Period: 12/01/2015 - 11/30/2016

Coverage For: Individual/Family | **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-855-333-5735.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$4000** single / **$12000** family for In-Network Provider **$0** for Non-Network Provider Does not apply to Preventive Care, Copayments, Prescription Drugs, lab services provided in a preferred lab.	You must pay all the costs up to the **deductible** amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the **deductible** starts over (usually, but not always, January 1st.) See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes; In-Network Provider Single: **$4000**, Family: **$12000** Non-Network Provider Single: **$0**, Family: **$0**	The **out-of-pocket limit** is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Balance-Billed Charges, Copayments, Pre-Authorization Penalties, Health Care This Plan Doesn't Cover, Premiums, Costs Related to Prescription Drugs Covered Under the Prescription Drug Plan.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the insurer pays?	No. This policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 3 describes any limits on what the insurer will pay for specific covered services, such as office visits.

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. See **www.anthem.com** or call **1-855-333-5735** for a list of participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Plans use the terms in-network, preferred, or participating to refer to providers in their network.
Do I need a referral to see a specialist?	Yes, you need written approval to see a specialist. There may be some providers or services for which referrals are not required. Please see the formal contract of coverage for details.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about excluded services.

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

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit	Not covered	————none————
	Specialist visit	$50 copay per visit	Not covered	————none————
	Other practitioner office visit	Chiropractor $50 copay per visit Acupuncture Not covered	Chiropractor Not covered Acupuncture Not covered	————none————
	Preventive care/screening/ immunizations	No charge	Not covered	————none————
If you have a test	Diagnostic test (x-ray, blood work)	Lab - Office No charge X-Ray - Office 0% coinsurance	Lab - Office Not covered X-Ray - Office Not covered	Lab - Office There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	Not covered	————none————

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.anthem.com/pharmacyinformation/	Tier 1 – Typically Generic	$10 copay/ prescription (retail only) and $20 copay/prescription (mail order only)	Not covered	You pay additional copays for retail fills that exceed a 30 day supply. Covers up to a 90 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)
	Tier 2 – Typically Preferred/Formulary Brand	$35 copay/ prescription (retail only) and $70 copay/prescription (mail order only)	Not covered	You pay additional copays for retail fills that exceed a 30 day supply. Covers up to a 90 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)
	Tier 3 – Typically Non-preferred/ non-Formulary Drugs	30% coinsurance (retail and mail order)	Not covered	$250 max per script per 30 day supply. $750 max per script per 90 day supply. $2500/single and $7500/family coinsurance annual max. Covers up to a 90 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)
	Tier 4 – Typically Specialty Drugs	30% coinsurance (retail and mail order)	Not covered	$250 max per script per 30 day supply. $750 max per script per 90 day supply. $2500/single and $7500/family coinsurance annual max. Covers up to a 90 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)
If you have outpatient Surgery	Facility Fee (e.g., ambulatory surgery center)	0% coinsurance	Not covered	$100 copay applies to preferred ambulatory surgical center locations.
	Physician/Surgeon Fees	0% coinsurance	Not covered	Costs may vary by site of service. You should refer to your formal contract of coverage for details.

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency Room Services	$250 copay before deductible and 0% coinsurance after deductible	$250 copay before deductible and 0% coinsurance after deductible	copay waived if admitted
	Emergency Medical Transportation	0% coinsurance	0% coinsurance	————none————
	Urgent Care	$50 copay before deductible and 0% coinsurance after deductible	$250 copay before deductible and 0% coinsurance after deductible	In Network Urgent Care benefit limited to preferred New Hampshire locations.
If you have a hospital stay	Facility Fee (e.g., hospital room)	0% coinsurance	Not covered	————none————
	Physician/surgeon fee	0% coinsurance	Not covered	————none————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit $25 copay per visit Mental/Behavioral Health Facility Visit - Facility Charges 0% coinsurance	Mental/Behavioral Health Office Visit Not covered Mental/Behavioral Health Facility Visit - Facility Charges Not covered	————none————
	Mental/Behavioral health inpatient services	0% coinsurance	Not covered	————none————
	Substance use disorder outpatient services	Substance Abuse Office Visit $25 copay per visit Substance Abuse Facility Visit - Facility Charges 0% coinsurance	Substance Abuse Office Visit Not covered Substance Abuse Facility Visit - Facility Charges Not covered	————none————

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Substance use disorder inpatient services	0% coinsurance	Not covered	————none————
If you are pregnant	Prenatal and postnatal care	0% coinsurance	Not covered	Copay applies to initial visit. Postnatal care subject to 0% coinsurance after deductible. Your doctor's charges for delivery are part of prenatal and postnatal care.
	Delivery and all inpatient services	0% coinsurance	Not covered	Applies to inpatient facility. Other cost shares may apply depending on services provided.
If you need help recovering or have other special health needs	Home Health Care	0% coinsurance	Not covered	————none————
	Rehabilitation Services	$50 copay per visit	Not covered	Coverage for physical therapy is limited to 20 visits per year, occupational therapy is limited to 20 visits per year, and speech therapy is limited to 20 visits per year.
	Habilitation Services	$50 copay per visit	Not covered	All rehabilitation and habilitation visits count towards your rehabilitation limit.
	Skilled Nursing Care	0% coinsurance	Not covered	Coverage is limited to 100 days per yearSeparate limit of 60 days annual max for inpatient physical rehabilitation..
	Durable medical equipment	0% coinsurance	Not covered	————none————
	Hospice service	No charge	Not covered	————none————
If your child needs dental or eye care	Eye exam	No charge	Not covered	Coverage is limited to 1 occurrences every 24 months.
	Glasses	Not covered	Not covered	————none————
	Dental check-up	Not covered	Not covered	————none————

Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Long- term care
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide.
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Routine eye care (adult)

Your Rights to Continue Coverage:

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

For more information on your rights to continue coverage, contact the plan at 1-855-333-5735. You may also contact your state insurance department, the Department of Labor's Employee Benefits
Security Administration
1-866-444-EBSA (3272)
www.dol.gov/ebsa/healthreform.

Your Grievance and Appeals Rights:

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

Anthem BlueCross BlueShield
ATTN: Appeals
P.O. Box 518
North Haven, CT 06473-0218

Or Contact:

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

New Hampshire Insurance Department
21 South Fruit Street, Suite 14
Concord, NH 03301
Consumer Hotline: 800-852-3416

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

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

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

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

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

About These Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $3,420
- **Patient pays:** $4,120

Sample care costs:

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

Patient pays:

Total Deductibles	$4,000
Co-pays	$0
Co-insurance	$0
Limits or exclusions	$120
Total	**$4,120**

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $1,350
- **Patient pays:** $4,050

Sample care costs:

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

Patient pays:

Total Deductibles	$4,000
Co-pays	$0
Co-insurance	$0
Limits or exclusions	$50
Total	**$4,050**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

Take care of yourself. Use your preventive care benefits.

Anthem BlueCross BlueShield

Getting regular checkups and exams can help you stay well and catch problems early. It may even save your life.

Our health plans offer the services listed in this preventive care flier at no cost to you.[1] When you get these services from doctors in your plan's network, you don't have to pay anything out of your own pocket. You may have to pay part of the costs if you use a doctor outside the network.

Preventive versus diagnostic care

What's the difference? Preventive care helps protect you from getting sick. Diagnostic care is used to find the cause of existing illnesses. For example, say your doctor suggests you have a colonoscopy because of your age when you have no symptoms. That's preventive care. On the other hand, say you have symptoms and your doctor suggests a colonoscopy to see what's causing them. That's diagnostic care.

Child preventive care

Preventive physical exams

Screening tests:

- Behavioral counseling to promote a healthy diet
- Blood pressure
- Cervical dysplasia screening
- Cholesterol and lipid level
- Depression screening
- Development and behavior screening
- Type 2 diabetes screening
- Hearing screening
- Height, weight and body mass index (BMI)
- Hemoglobin or hematocrit (blood count)
- HPV screening (female)
- Lead testing
- Newborn screening
- Screening and counseling for obesity
- Oral (dental health) assessment when done as part of a preventive care visit
- Screening and counseling for sexually transmitted infections
- Vision screening[2] when done as part of a preventive care visit

Immunizations:

- Diphtheria, tetanus and pertussis (whooping cough)
- Haemophilus influenza type b (Hib)
- Hepatitis A and Hepatitis B
- Human papillomavirus (HPV)
- Influenza (flu)
- Measles, mumps and rubella (MMR)
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Polio
- Rotavirus
- Varicella (chicken pox)

Women's preventive care

- Well-woman visits
- Breast cancer, including exam, mammogram, and, including genetic testing for BRCA 1 and BRCA 2 when certain criteria are met[6]
- Breastfeeding: primary care intervention to promote breastfeeding support, supplies and counseling (female)[3,4]
- Contraceptive (birth control) counseling
- FDA-approved contraceptive medical services provided by a doctor, including sterilization
- Counseling related to chemoprevention for women with a high risk of breast cancer
- Counseling related to genetic testing for women with a family history of ovarian or breast cancer
- HPV screening[4]
- Screening and counseling for interpersonal and domestic violence
- Pregnancy screenings: includes, but is not limited to, gestational diabetes, hepatitis, asymptomatic bacteriuria, Rh incompatibility, syphilis, iron deficiency anemia, gonorrhea, chlamydia and HIV[4]
- Pelvic exam and Pap test, including screening for cervical cancer

The preventive care services listed are recommendations as a result of the Affordable Care Act (ACA, or health care reform law). The services listed may not be right for every person. Ask your doctor what's right for you, based on your age and health condition(s).

This sheet is not a contract or policy with Anthem Blue Cross and Blue Shield. If there is any difference between this sheet and the group policy, the provisions of the group policy will govern. Please see your combined Evidence of Coverage and Disclosure Form or Certificate for Exclusions and Limitations.

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Adult preventive care

Preventive physical exams

Screening tests:

- Alcohol misuse: related screening and behavioral counseling
- Aortic aneurysm screening (men who have smoked)
- Behavioral counseling to promote a healthy diet
- Blood pressure
- Bone density test to screen for osteoporosis
- Cholesterol and lipid (fat) level
- Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and CT colonography (as appropriate)
- Depression screening
- Type 2 diabetes screening
- Eye chart test for vision[2]
- Hearing screening
- Height, weight and BMI
- HIV screening and counseling
- Obesity: related screening and counseling
- Prostate cancer, including digital rectal exam and PSA test
- Sexually transmitted infections: related screening and counseling
- Tobacco use: related screening and behavioral counseling
- Violence, interpersonal and domestic: related screening and counseling

Immunizations:

- Diphtheria, tetanus and pertussis (whooping cough)
- Hepatitis A and Hepatitis B
- HPV
- Influenza (flu)
- Meningococcal (meningitis)
- Measles, mumps and rubella (MMR)
- Pneumococcal (pneumonia)
- Varicella (chicken pox)
- Zoster (shingles)

A word about pharmacy items

For 100% coverage of over-the-counter (OTC) drugs and other pharmacy items listed below, the person receiving the item(s) must meet the age criteria. You need to work with your in-network doctor or other health care provider to get a prescription for the item(s) and take the prescription to an in-network pharmacy. Even if the item(s) do not "need" a prescription to purchase them, if you want the item(s) covered at 100%, you have to have the prescription.

Child preventive drugs and other pharmacy items – age appropriate

- Fluoride supplements for children from birth through 6 years old
- Iron supplements for children 0-12 months

Adult preventive drugs and other pharmacy items – age appropriate

- Aspirin use for the prevention of cardiovascular disease including aspirin for men ages 45-79 and women ages 55-79
- Tobacco cessation products including select generic prescription drugs, select brand-name drugs with no generic alternative, and FDA-approved over-the-counter products, for those 18 and older

Women's preventive drugs and other pharmacy items – age appropriate

- Contraceptives including generic prescription drugs, brand-name drugs with no generic alternative, and over-the-counter items like female condoms or spermicides [4, 5]
- Folic acid for women 55 years old or younger
- Vitamin D for women over 65

1 The range of preventive care services covered at no cost share when provided in-network are designed to meet the requirements of federal and state law. The Department of Health and Human Services has defined the preventive services to be covered under federal law with no cost share as those services described in the U.S. Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents and women supported by the Health Resources and Services Administration (HRSA) Guidelines. You may have additional coverage under your insurance policy. To learn more about what your plan covers, see your certificate of coverage or call the Customer Care number on your ID card.

2 Some plans cover additional vision services. Please see your contract or Certificate of Coverage for details.

3 Breast pumps and supplies must be purchased from an in-network medical provider for 100% coverage; we recommend using an in-network durable medical equipment (DME) supplier.

4 This benefit also applies to those younger than 19.

5 A cost share may apply for other prescription contraceptives, based on your drug benefits.

6 Check your medical policy for details.

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 Pam Iversen, phone # 603-692-6598.

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)
Great Bay Oral Surgery Associates, P.A.	04-3354065
5. Employer address	**6. Employer phone number**
259 Route 108	603-682-6598

7. City	8. State	9. ZIP code
Somersworth	NH	03878

10. Who can we contact about employee health coverage at this job?	
Pam Iversen	
11. Phone number (if different from above)	**12. Email address**
	pi3@comcast.net

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:

☑ Some employees. Eligible employees are:

those that work the required hours (see HR to confirm your eligibility) and have satisfied the waiting period (1st of the month following date of hire)

- With respect to dependents:

☑ We do offer coverage. Eligible dependents are:

refer to attached Dependent Eligibility guidelines

☐ 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)

Eligible employees

To be eligible, an employee must be a:

- Full-time employee working at least 30 hours per week and paid by W-2.
- Part-time employee working no less than 15 hours per week. Note: An employer is not required to offer benefits to part-time employees; however, employers who offer benefits to part-time employees must offer benefits to all part-time employees who meet the same criteria.

Eligible dependents

To be eligible, a dependent may be:

- The employee's spouse or the employee's domestic partner (if you offer domestic partner coverage). For domestic partner criteria, see Affidavit of Domestic Partnership.
- Legally separated or divorced spouse (ex-spouse) may be eligible for coverage if continuation of coverage is elected under federal or state law. As of January 1, 2008, New Hampshire law allows a divorced spouse who is currently covered under the group plan to remain on the subscriber's plan for a period not to exceed 36 months (Refer to SB197).
- A natural or legally adopted child of the employee, the employee's spouse or the employee's domestic partner (if you offer domestic partner coverage), who is under the age of 26 or incapacitated and incapable of self-support due to a mental disorder, developmental disability, mental retardation, or physical handicap.
- A child for whom the employee, the employee's spouse or the employee's domestic partner (if you offer domestic partner coverage) is the legal guardian. The child(ren) must qualify as an eligible dependent as defined in your *Certificate*.
- For health coverage only, child(ren) who the group has determined are covered under a Qualified Medical Child Support Order (QMSCO).

Note: Any child(ren) must be within the age limit and criteria defined in the group *Certificate* and *Schedule of Benefits*. Appropriate documentation is needed to confirm legal guardianship.

Important Note for Employees:

This COBRA Notice is required to be distributed to any eligible employee who chooses to enroll on Great Bay Oral Surgery Associates, P.A. group health plan. You can disregard this notice if you have decided not to enroll on the company sponsored health plan.

General Notice of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan) with Great Bay Oral Surgery Associates, P.A. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becomes entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: **HUMAN RESOURCES DEPT**. The notice will then be forwarded to Landmark Benefits.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Human Resources Dept.
Great Bay Oral Surgery Associates, P.A.
Telephone: (603) 692-6598

20 Mary E. Clark Drive, Suite 10
Hampstead, NH 03841
Telephone: 603-329-4535
Fax: 603-329-6820