



The Standard®
Positively different.



Group Dental Insurance

FOR EMPLOYEES OF BROWARD COUNTY GOVERNMENT

Answers to your questions about coverage from Standard Insurance Company



About This Booklet

This booklet is designed to answer some common questions about the Group Dental Insurance coverage offered to the eligible employees in your company. It is not intended to provide a detailed description of the coverage.

If coverage becomes effective and you become insured, you will receive a certificate containing a detailed description of the insurance coverage including the definitions, exclusions, limitations, restrictions and terminating events. The controlling provisions will be in the group policy. Neither this booklet nor the certificate modify the group policy or the insurance coverage in any way.



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Group Dental Insurance Features

Standard Insurance Company has been offering Dental insurance plans for over 20 years. Our plan designs are wide-ranging and flexible. As an insured member of one of our plans, you will experience a state-of-the-art claim processing system. You can also take advantage of our toll-free customer service number, which offers callers an interactive voice response system for convenient access to claim and benefit information. Claim and benefit information are also available online.

We are pleased to offer you the following Dental Plan:

High PPO Plan

How the High PPO Plan Works

You visit any dentist

Your dentist bills the insurance company for each procedure performed¹

You choose whether to receive a pre-determined percentage of the allowable fee for each procedure or have that amount sent directly to your dentist

Your dentist then bills you for any balance due on your account

The reimbursement percentage is higher if you use a dentist within the Ameritas PPO Network

Annual deductible and maximum reimbursement apply

More information on this plan is provided in the following pages to assist you in your decision. You can also visit our table at your upcoming open enrollment meeting to get answers to your questions.

High PPO Plan

The High PPO plan reimburses you a given percentage of the allowable charge for a procedure. The reimbursement percentage and the allowable charge used in the High PPO plan are based on a) the type of procedure, and b) whether your dentist is part of the participating provider network. Here's how it works:

Coinsurance	In Network	Out of Network
Type 1 Preventative	100%	70%
Type 2 Basic	80%	60%
Type 3 Major	50%	40%
Deductible	\$50/Each Calendar Year Type 2 & 3 Waived Type 1 \$150/family	\$50/Each Calendar Year Type 2 & 3 Waived Type 1 \$150/family
Maximum (<i>per person</i>)	\$1,500 per calendar year	\$1,000 per calendar year
Allowance	PPO Max	90th U&C

Orthodontia Summary - Child Only Coverage

	In Network	Out of Network
Allowance	Discounted Fee	U&C
Coinsurance	50%	50%
Lifetime Maximum (per person)	\$1,000	\$1,000
Waiting Period	12 months New Hires Only	12 months New Hires Only

** Please refer to the Q&A section at the back of this brochure for detailed information on how payments are processed.

Let's look at a few examples:

Adult Cleaning (code 1110)		
	Participating dentist	Non-participating dentist
Dentist Fee	\$51 ¹	\$89 ²
Allowable Charge	\$51	\$89
Percentage of Reimbursement	100%	70%
Amount Reimbursed	\$51	\$62
You Pay	\$0	\$27

Restoration³ (code 2330)		
	Participating dentist	Non-participating dentist
Dentist Fee	\$72	\$165
Allowable Charge	\$72	\$165
Percentage of Reimbursement	80%	60%
Amount Reimbursed	\$58	\$99
You Pay	\$14	\$66

Bitewing X-Rays (code 272)		
	Participating dentist	Non-participating dentist
Dentist Fee	\$21	\$45
Allowable Charge	\$21	\$45
Percentage of Reimbursement	100%	70%
Amount Reimbursed	\$21	\$32
You Pay	\$0	\$13

1 This is the fee negotiated with our participating providers in zip codes starting with 333.

2 For the purposes of the examples in this booklet, for fees charged by non-participating dentists, we used an amount calculated such that it is no more than the fee charged by nine out of every 10 dentists in zip codes starting with 333.

3 Assumes that the annual deductible has been satisfied.

Root Canal³ (code 3330)	Participating dentist	Non-participating dentist
Dentist Fee	\$542	\$1179
Allowable Charge	\$542	\$1179
Percentage of Reimbursement	80%	60%
Amount Reimbursed	\$434	\$707
You Pay	\$108	\$472

Bi-Weekly Cost of the High PPO Plan

You only	\$13.21
You and your spouse/domestic partner	\$26.23
You and your child(ren)	\$30.77
You, your spouse/domestic partner and your child(ren)	\$43.78

Additional information is provided under Commonly Asked Questions. We will also be available to answer your questions at your upcoming open enrollment meeting.

Commonly Asked Questions

Enrollment

Why should I choose Standard Insurance Company for my Dental coverage?

Standard Insurance Company (The Standard) is the same carrier that has provided Broward County with their Life and Long Term Disability coverage for the past 14 years. The Standard ranks among the top insurance carriers providing Group Dental insurance, with a large, nationwide network of over 95,000 dentists (through the Ameritas Network) and widespread coverage throughout South Florida. Our coverage balances affordability with flexible plans and quality care for employees.

Can I be enrolled in another Dental plan outside of the plans offered by the County?

Yes, you can. For example, you might be covered by this plan and your spouse's Dental plan. When you file a claim, you will be asked for information about your coverage by other Dental plans. With this information, we will coordinate benefits with the other Dental plan.

When can I enroll?

You can enroll when you are first eligible as a new employee. You also need to enroll during the annual open enrollment period. If you enroll more than 31 days after you are first eligible, you will not be eligible for any reimbursement during the first 12 months of your coverage, except for Preventative (Type 1) and Basic (Type 2) procedures. If, after a life-changing event, you have a new spouse/domestic partner or dependent, you have 31 days after the event to enroll that person without penalty. You must re-enroll for coverage each year during your annual open enrollment period.

³ Assumes that the annual deductible has been satisfied.

Changing Dental Plans During Open Enrollment

Will I be subject to limited benefits if I am currently in the County's DHMO Plan and switch over to The Standard's plan?

No, you will not be subject to limited benefits if you were enrolled in the County's DHMO plan and switch to The Standard's plan during the annual open enrollment period. However, if you had a tooth extracted before you become insured under one of The Standard's plans, you will not be reimbursed to replace that tooth. Also, orthodontia treatment that has already begun will not be reimbursed.

Will I be subject to limited benefits if I am not enrolled in one of the County's Dental plans?

If you are not enrolled in one of the County's Dental plans, no benefits will be payable for expenses incurred during the first 12 months of your coverage, except for Preventative (Type 1) and Basic (Type 2) procedures. This provision does not apply to newly hired employees who enroll within 31 days of becoming eligible for coverage.

Participating Provider Network

How do I know if my dentist is part of the participating provider network?

Ask your dentist if he or she is part of the Ameritas Preferred Provider Network. This is the network used by The Standard. You can also search for your dentist online through our list of participating providers at www.standard.com/services/ppo_providers.html.

How will my dentist know that I am part of The Standard's Dental plan?

When visiting your dentist, just show your Dental ID card. You will receive your Dental ID card along with your certificate of coverage.

Reimbursement

How do I file a claim? Do I have to use a form provided by The Standard?

The Standard accepts a Universal Claim Form that most dentists have in their offices. You can also get a form at www.standard.com/services/ppo_providers.html.

Who completes and submits the claim form?

If you go to a participating dentist, your dentist will complete and submit the claim on your behalf. If you go to a non-participating dentist, you may be required to complete and submit the claim form. Instructions are provided on the form.

Do I have to pay the dentist before I get reimbursed?

You have to discuss this with your dentist. Most dentists will wait for payment until the claim has been processed; others may request to be paid at the time of service.

How does the reimbursement work?

You have two options. You may choose to have the reimbursement sent to you or directly to the dentist. There is a place on the claim for you to indicate your choice. Even if payment is made directly to the dentist, you will receive a copy of the Explanation of Benefits showing what the dentist was paid.

How long will it take before I get reimbursed?

Approved claims are usually paid within seven to ten working days and often sooner.

Do I have to obtain a pre-authorization for some services?

No, you do not have to obtain pre-authorization for any claim. However, we recommend that you get an estimate from the dentist when the cost is expected to be \$200 or more. Information about pre-treatment estimate is included on The Standard's claims form. A pre-authorization is for your benefit so there will be no surprises about what your benefit will be for your treatment.

Your Benefits

Am I covered for all procedures?

Most ADA (American Dental Association) procedures are covered, with the exception of orthodontia which is only available to children. Your certificate of insurance contains the list of all procedures covered.

What can participants expect to pay out of pocket when they visit a specialist?

The fees charged by a specialty dentist (a pediatric dentist or endodontist, for example), in general, are higher than those of a general dentist, due to their specialty training. The fees for specialists and general dentists who participate in our network are discounted to a maximum allowable charge (MAC) for each procedure. Because the specialist fees are typically higher, the out of pocket cost can be higher, even for a participating provider.

I am getting a tooth extracted. Do I have to replace it right away?

If you have a tooth extracted while covered under The Standard's plan, your replacement must occur within six months from the date of extraction. If you had a tooth extracted before you became covered under The Standard's plan, you are not eligible for reimbursement to replace that tooth.

Are there any exclusions and/or limitations that apply to my coverage?

Yes, there are both exclusions and limitations. For example, one exclusion is that the plan does not pay for treatment that is for cosmetic purposes. An example of a limitation is that the plan allows benefits for one adult cleaning and exam each six months. Please refer to your group insurance certificate for a detailed description of all policy exclusions and limitations.

What if I don't use my entire Annual Maximum? Can I carry forward my unused Annual Maximum to the next year?

Yes, you may be able to do this. Your Dental plan contains a Max Builder feature. As long as: 1) you go to a dentist and submit at least one claim for Dental expenses during the benefit year and 2) your Dental benefits payable during the benefit year are \$500 or less, then you will be able to carry over to the next benefit year \$250 to be added to your new Annual Maximum. And, if you receive Dental services from a Participating Dentist during the year, you will receive an additional \$100 for a total \$350 carry over. The maximum carryover amount you can accumulate over multiple years is \$1,000. If you do not submit a Dental claim during a benefit year, your accumulated carry over amount will be lost. Here is an example of how Max Builder

can work: During 2010, a Member visits her dentist twice. Total benefits payable for expenses incurred during those visits is \$420. Her dentist is a participating dentist. For 2011, she can carry over a total of \$350 to be added to her 2011 Annual Maximum.

I have a child who will be starting orthodontia treatment. How will orthodontia benefits be paid?

Orthodontia benefits are typically paid over a period of two years. The first benefit is paid about three months after treatment begins and payments continue to be made every three months after that until the Orthodontia maximum benefit is reached. Payments are made automatically as long as the patient remains covered by the Dental plan. There is no need for the Member or orthodontist to submit periodic claims.

Customer Service

How can I reach you if I have more questions?

You can reach one of our representatives Monday through Friday, 9:00 a.m. to 8:00 p.m. Eastern time, by calling **800.547.9515**. You can also call this number to access our interactive voice system to verify eligibility or claim status, request ID cards or get a high-level benefit summary. The system is available at all times.

You can also get this information online at **www.standard.com/services/index.html**, as well as consult the participating provider network directory, obtain an explanation of benefit, a claim form or the HIPAA Notice of Privacy Practices.

Standard Insurance Company

Standard Insurance Company has earned a solid reputation for its quality products, expert resources, superior service, steady growth, innovation and strong financial performance. Founded in 1906, Standard Insurance Company is a leader in the group disability, life and dental insurance market, while also offering individual disability and retirement plans for groups and individuals.

For more information about group dental insurance coverage, or for assistance, please contact your human resources department.



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