American Federation of Government Employees District #11

Dental Highlight Sheet

High Plan Option (Alaska, Wyoming, Montana, Colorado)

Effective Date: 5/1/2009

Coinsurance	
Type 1	100%
Type 2	80%
Type 3	50%
Deductible	$50/Calendar Year Type 2 & 3 Waived Type 1 No Family Maximum
Maximum *(per person)*	$2,000 per calendar year
Max Builder	Included
Allowance	90th U&C
Waiting Period	None

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

Type 1

- 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)
- Sealants (age 13 and under)
- Space Maintainers

Type 2

- Restorative Amalgams
- Restorative Composites
- Denture Repair
- Simple Extractions
- Endodontics (nonsurgical)

Type 3

- Onlays
- Crowns (1 in 10 years per tooth)
- Crown Repair
- Endodontics (surgical)
- Periodontics (nonsurgical)
- Periodontics (surgical)
- Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 10 years)
- Complex Extractions
- Anesthesia

Bi-Monthly Rates – (Standard's Premium + TPA Administrative Expense)

Alaska

	Total
Employee (EE)	$30.25
EE + Spouse	$55.50
EE + Children	$55.50
EE + Spouse & Children	$82.50

Wyoming, Montana, Colorado

	Total
Employee (EE)	$15.25
EE + Spouse	$29.50
EE + Children	$35.25
EE + Spouse & Children	$48.25

THE STANDARD INSURANCE COMPANY

Dental Highlight Sheet

About The Standard

As a leading provider of employee benefits products and services, Standard Insurance Company is dedicated to meeting the unique insurance needs of each customer. More than 29,000 groups trust The Standard for group insurance products and services, and the company covers nearly 7 million employees.

Founded in Portland, Oregon, in 1906, The Standard has built a national reputation for delivering quality insurance products, personalized service and strong financial performance. The Standard wrote its first group insurance policy in 1951, and it remains in force today as a testament to the company's commitment to building successful long-term relationships.

Customer Service

Your local Standard Insurance Company Employee Benefits Sales and Service Office will provide most of the ongoing service for your plan and can be reached at 800.633.8575 during normal business hours. We will assign your company a service representative who will provide regular contact and address questions and concerns related to the plan or the services we provide.

We also make it easy for covered employees and dentists to contact us to confirm eligibility or request claims information. Our customer service representatives are available Monday through Friday from 6:00 a.m. until 5:00 p.m. Pacific Time. An interactive voice response system for eligibility and claim information is accessible from 5:00 a.m. to midnight Pacific Time, Monday through Thursday, and from 5:00 a.m. to 5:30 p.m. on Friday.

Max Builder

This dental plan includes a valuable feature that allows qualifying plan participants to carryover part of their unused annual maximum. *A participant 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. Employees 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 participant 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.

Benefit Threshold: $750
Dental benefits received for the year cannot exceed this amount

Annual Carryover Amount: $400
Max Builder amount is added to the following year's maximum

Maximum Carryover: $1,200
Maximum possible accumulation for Max Builder

PPO Information

Employees and dependents have access to an extensive nationwide network of member dentists. The cost-saving benefits of visiting a PPO member dentist are automatically available to all employees and dependents who are covered by any of The Standard's dental plans and who live in areas where the nationwide PPO is available. To find member dentists in your area, visit: **http://www.standard.com/services/ppo_providers.html.** The plan you belong to is PPO - Nationwide.

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.

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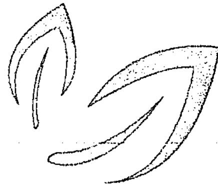


Dental Voluntary Dental Enrollment/Change Form

The Standard Insurance Company

Mark all boxes and complete all sections that apply. Return completed form to Camco Benefit Services.

APPLICANT

Your Name (Last, First, Middle)	Group Name	Group Number(s)
	American Federation of Government Employees District #11	**647035**

Your Address	City	State	ZIP	Phone Number

Your Soc. Sec. No.	Date of Birth	Gender	Local #	E-mail Address	Job Title/Occupation

DENTAL

Dental ☐ Low Dental Plan ☐ High Dental Plan ☐ Orthodontic Dental Plan

Marital Status ☐ Single ☐ Married ☐ Divorced

Coverage requested for ☐ You, your Spouse and Children ☐ You and your Spouse ☐ You only ☐ You and your Children (no Spouse)

Are you covered for dental insurance under another plan? ☐ Yes ☐ No Are one or more Dependents? ☐ Yes ☐ No

List Dependents to enroll or delete. (Last name if different, First, Middle Initial)	Sex M	Sex F	Date of Birth	*List Dependents to enroll or delete.* (Attach sheet for additional Dependents if needed.)	Sex M	Sex F	Date of Birth
Spouse				Child 2			
Child 1				Child 3			

CHANGE

Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.

☐ Add Dependent ☐ Delete Dependent ☐ Name Change

Date of add/delete ____________________ Former name ____________________ ☐ Other ____________________

SIGNATURE

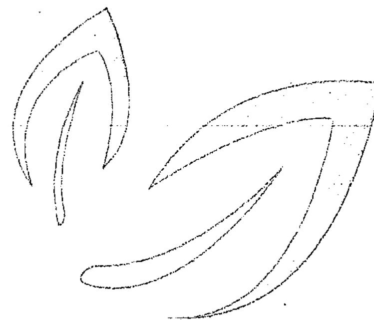
I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.

Member/Employee Signature Required	Date (Mo/Day/Yr)

Camco Benefit Services - Complete this section. Retain form for your records.

Date of Hire/Rehire	Hrs. Worked Per Wk.

camco
benefit services



www.CAMCOBENEFITSERVICES.COM
1-800-845-4669

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS

(Automated Clearing House Debits, ACH)

NAME (PLEASE PRINT)____________________ **PHONE**____________________

EMAIL____________________ **UNION.LOCAL#**__________

I (we) hereby authorize **Camco** to initiate debit entries to my (our) account indicated below and financial institution named below to debit the same such account. **I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.**

☐ **CHECKING or** ☐ **SAVINGS** (account type)

☐ **BI-WEEKLY or** ☐ **MONTHLY** (debit type)

A CHECK FOR ONE MONTH'S PREMIUM MUST ACCOMPANY THIS FORM

BANK NAME____________________

TRANSIT/ROUTING/ABA NUMBER____________________

ACCOUNT NUMBER____________________

This authorization is to remain in full force and in effect until CAMCO has received WRITTEN notification of TERMINATION in such time and in such manner to afford CAMCO and DEPOSITORY a reasonable opportunity to act.

SIGNED____________________ DATE ____/____/_____

This dental/vision agreement is for a period of 12 months from your initial effective date.

THERE WILL BE A **$35.00** SERVICE FEE FOR ANY RETURNED ITEMS OR INSUFFICIENT FUNDS.

On all ACH transactions there will be a .25 bank fee added

Please Mail with a check for one month's premium of coverage to:
Camco Benefit Services ~PO BOX 5667~ Lacey, WA 98509