DENTAL DESCRIPTION OF BENEFITS
Fisher Island Community Association

*****Please take this information to the dentist, along with your ID card*****

Effective Date: 08/01/2008

CALENDAR YEAR DEDUCTIBLE (APPLIES TO CLASS II & III)

Individual	$50
Family	3 individuals

CALENDAR YEAR MAXIMUM BENEFIT (APPLIES TO CLASS I, II & III)

Each Eligible Family Member	$1,000

ORTHODONTIA (APPLIES TO CHILD ONLY)

Deductible	$0
Lifetime Maximum	$1,500

	CLASS I	CLASS II	CLASS III	CLASS IV
	DIAGNOSTIC & PREVENTIVE	BASIC RESTORATIVE	MAJOR RESTORATIVE	ORTHODONTIA
Coinsurance:	80%	80%	50%	50%
Description of Services: MAC plan – fee schedule applies out of network	Oral evaluations, routine cleanings, fluoride treatments, sealants, bitewing X-rays, intraoral complete series X-rays or panoramic film, genetic test for susceptibility to oral diseases	Intraoral periapical X-rays, fillings, including tooth-colored fillings on posterior teeth, extractions, biopsy (including brush biopsy), periodontics, localized delivery of antimicrobial agents, root canal therapy	Crowns, dentures, fixed bridges, space maintainers, general anesthesia and intravenous sedation	Orthodontic extractions, full or partial bands, appliances (removable and fixed)

* Dental Health Alliance® – For referral to a PPO provider, call 800.442.7742 or go to www.assurantemployeebenefits.com.

*** Routine cleanings, exams, fluoride treatments – 1 in any 6 months. Periodontal maintenance procedure (Class II) – 1 in any 3 months when combined with routine cleanings. Total number of combined periodontal maintenance procedures and routine cleanings not to exceed 4 in any 12 months.

Pre-Determination: If the charge for any dental treatment is expected to exceed $300, Assurant Employee Benefits recommends a dental treatment plan be submitted to claims for review before treatment begins.

LOCAL OFFICE:

Assurant Employee Benefits
5401 West Kennedy Blvd., Suite 760, 7th Floor
Tampa, FL 33609

T 813.286.7736 800.654.7808 F 813.289.8315

CLAIMS/CUSTOMER SERVICE:

Assurant Employee Benefits
PO Box 2940
Clinton, IA 52733
800.442.7742
Electronic Claims: Payor 70408

This sheet is intended as a summary of benefits for a non-voluntary dental plan. Please consult your certificate booklet for complete coverage details.

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Effective Date: 08/01/2008

FREQUENTLY ASKED DENTAL ENROLLMENT QUESTIONS

QUESTION: **What are my deductibles?**

ANSWER: Your plan has a $50 per person deductible; the family deductible is satisfied when 3 family members meet their $50 per person deductible. The deductible is waived for Preventive services. Your Orthodontia coverage has no deductible.

QUESTION: **Can I see my own dentist?**

ANSWER: Yes, this plan allows you to see any dentist you want. However, the DHA® PPO helps you to reduce your out-of-pocket cost. Treatment is available from dentists who do not participate in DHA®, but their fees are subject to a Maximum Allowable Charge (MAC). A MAC is the most Assurant Employee Benefits will pay per procedure to a non-participating dentist. In addition to any deductible and coinsurance amounts, you are also responsible for fees in excess of the MAC. If your dentist is not currently a DHA® provider, you can nominate your dentist for membership by calling toll-free 800.442.7742.

QUESTION: **What is DHA® and how do I locate a PPO provider?**

ANSWER: Dental Health Alliance® L.L.C., or DHA®, is a national dental Preferred Provider Organization (PPO) owned and operated by Union Security Insurance Company and Assurant, Inc. DHA® PPO dentists will discount services not covered by this plan.

You may find a DHA® provider by visiting the Assurant Employee Benefits website at www.assurantemployeebenefits.com - Select "For Members" - "Find a dentist" - "Dental Health Alliance". Or call customer service at 800.442.7742. A service representative can confirm whether your current dentist is a Dental Health Alliance PPO panel member.

QUESTION: **I was covered by my employer's prior plan. Do I have any waiting periods?**

ANSWER: If you were covered under the prior carrier's dental plan, you do not have a waiting period for Class III Major services or Class IV Orthodontia services if you enroll within 31 days of becoming eligible for this plan.

QUESTION: **When I visit the dentist, do I have to fill out a claim form?**

ANSWER: No. Claim forms are available, but they are *not* required. Assurant Employee Benefits will accept a dentist's invoice of services in lieu of a claim form. You will, however, need to provide your dentist with your group number and your social security number, which serve as your identification for all claims.

QUESTION: **Who is a Late Entrant?**

ANSWER: A "Late Entrant" is anyone who enrolls in this dental plan more than 31 days after becoming eligible for the plan. Late Entrants may be subject to additional waiting periods for Class II Basic, Class III Major, and Class IV Orthodontia services, so there is an advantage to being a "Timely Entrant" who enrolls in the plan within 31 days of becoming eligible.

QUESTION: **Who are eligible dependents?**

ANSWER: Those qualified to be covered under your dental plan include your spouse and unmarried children under the age of 19 or 25 if a full-time or part-time student, or less than age 25 if living at home and dependent upon the insured for support and maintenance. State variations, limitations, and exclusions may apply.

The insurance policy or policies described in this document are underwritten by Union Security Insurance Company, a subsidiary of Assurant, Inc. Assurant Employee Benefits, a business unit of Assurant, Inc., markets life, disability and dental benefits plans as well as related products and services.

This sheet is intended as a summary of benefits for a non-voluntary dental plan. Please consult your certificate booklet for complete coverage details.

Vision Discount Services

ACCESS PLAN

Your dental plan includes a vision discount plan through Vision Service Plan (VSP). The vision plan includes discounts on exams (including contact lens exams) and the purchase of eyeglasses, sunglasses and other prescription eyewear when provided by VSP doctors. VSP is available for you and everyone covered on your dental plan!

Services Available from a VSP Doctor

- **Eye Exams** – 20% discount applied to VSP doctor's usual and customary fees for eye exams[1]
- **Glasses** – 20% discount applied to VSP doctor's usual and customary fees for complete pairs of prescription glasses and spectacle lens options[2]
- **Contact Lenses** – 15% discount on VSP network doctor's contact lens exam fee.
- **Laser VisionCare℠** – VSP has contracted with many of the nation's laser surgery facilities and doctors, offering you a discount off PRK and LASIK surgeries, available through contracted laser centers

Other Valuable Features for You

- Immediate savings when using a VSP doctor
- You may use the discounts as often as you wish
- No waiting periods
- No deductibles
- No claim forms to fill out

How to Use VSP

Locate a VSP doctor near you. You may either use our Web-based doctor locator at www.vsp.com, or call VSP at 800.877.7195 to request a doctor listing.

Identify yourself as a VSP member and be prepared to provide the *enrolled member's* social security number when you make your appointment. (The VSP doctor will verify your eligibility and vision plan coverage, and will obtain authorization for services and materials. If you are not currently eligible for services, the VSP doctor is responsible for communicating this to you.)

Your fees are automatically reduced at the time of service – with no claim forms to fill out!

THIS VISION DISCOUNT PLAN IS NOT INSURANCE.

[1]Note: Does not apply to contact lens services. See contact lens section for applicable discount.
[2]Discounts only offered through the VSP doctor who provided an eye exam within the last 12 months.

VSP Member Services Support: 800.877.7195
Visit our Web site at www.vsp.com

VSP

Employee Dental Application—Florida

ASSURANT Employee Benefits

G. O. no. ________

Group policy/participant no.	Account no.	Cert. no.	Employer	Employment location/phone no.

Employee name Last First Initial	Full-time employ. date Mo. Day Yr.	Part-time employ. date Mo. Day Yr.	Sex ☐M ☐F	Married ☐Yes ☐No	Children ☐Yes ☐No

Employee date of birth Month Day Year	No. hrs. per week ________	Job title or position	State of residence	Employee Soc. Sec. no.

Status: *(If status area is not completed, we consider the employee to be active.)*

☐ Retired ☐ Continuation ☐ Leave of absence ☐ Other ________

Reason ________ Date ________

Please mark **X** in box before the coverages you are applying for if you are eligible for them under your employer's plan:

Employee: ☐ Dental

Dependent: ☐ Dental **Please** mark **X** in box before the dependents to be covered: ☐ Spouse ☐ Children

If spouse coverage is being applied for, complete the following.

Name of Spouse	Date of Birth Month Day Year	Social Security No.	Employer	Current Dental Insurance Carrier

Write in the names and dates of birth of children to be covered *(subject to plan provisions)*.

____

____

Were you covered under another dental plan within the last 31 days? ☐ No ☐ Yes

If "Yes," termination date ________ Reason for termination of other coverage ________

***NOTE—** Coverages not specifically elected will not be made effective, even if not refused.
ELECTIONS NOT VALID WITHOUT SIGNATURE.

If coverage is refused, provide the reason for refusal. ________

IMPORTANT NOTICE TO APPLICANT — PLEASE READ CAREFULLY

My signature on this application certifies that I:

(1) Apply for the coverage designated for which I am eligible under my employer's plan with Union Security Insurance Company. (2) Understand if coverage has been refused, I am not entitled to benefits under that coverage and that if I want to apply later, I understand I will not be entitled to benefits until the expiration of the Late Entrant Limitation period specified in the policy. (3) Authorize any required deductions from my earnings. (4) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief. (5) Understand that I must meet the eligibility requirements specified in my policy/participation agreement to remain insured. (6) Understand that I have the right to select any dental care provider of my choice. (7) Understand that the dental plan includes a pre-estimate provision, that will advise me in advance of the benefits I may be eligible for if the procedure is performed. (8) When necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

This will certify that I HAVE read and understand the above important notice.

Signature ________ Date ________

Union Security Insurance Company

Mail to: **Assurant Employee Benefits** PO Box 2939 Clinton Iowa 52733-2939