Standard Select
Group Dental Insurance
Flexible Dental Plans for Small Business

Standard Insurance Company
The Standard Life Insurance Company of New York

Standard Insurance Company is licensed to issue insurance in all states except New York. The Standard Life Insurance Company of New York is licensed to issue insurance in only the state of New York.
Designed To Meet The Needs Of Small Businesses

Finding employee benefits that meet the needs of your small business can be challenging, but The Standard offers a solution. We’ve designed small group insurance products that enable business owners with as few as two employees to provide valuable coverage. These easy-to-administer plans offer you value through the right combination of features and services.

This booklet discusses our group Dental insurance, with optional eye care coverage. We also offer Standard Select group Life with Accidental Death & Dismemberment (AD&D) coverage, Long Term Disability (LTD) and Short Term Disability (STD) insurance plans, and optional Dependents Life, available with Group Life coverage. You may choose Standard Select Dental coverage on a standalone basis or work with your insurance advisor to build a comprehensive employee benefits package.

‡ The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Oregon, in all states except New York, where insurance products are offered by The Standard Life Insurance Company of New York of White Plains, New York.

Smile

(n.) A facial expression displaying amusement or pleasure, often with an upturned mouth and exposed front teeth.
Is Your Business Eligible for Group Dental Insurance?
The guidelines below will help you determine whether your company meets the basic criteria for our group Dental plans.

## Eligible For Coverage
To be eligible, your small business must:

<table>
<thead>
<tr>
<th>Icon</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>🧑‍💼</td>
<td>Have two or more eligible employees[^2]</td>
</tr>
<tr>
<td>💰</td>
<td>Be financially sound and provide stable, year-round employment</td>
</tr>
<tr>
<td>📝</td>
<td>Be structured as a corporation, partnership or proprietorship</td>
</tr>
<tr>
<td>👥</td>
<td>Be at least two years old</td>
</tr>
<tr>
<td>🙋‍♂️</td>
<td>Have an employer/employee relationship</td>
</tr>
<tr>
<td>📅</td>
<td>Have a central office for billing and insurance record maintenance</td>
</tr>
</tbody>
</table>

## Not Eligible For Coverage
In general, companies are not eligible if:

<table>
<thead>
<tr>
<th>Icon</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>⚠️</td>
<td>More than 50 percent of the employees are related</td>
</tr>
<tr>
<td>⏳</td>
<td>They changed insurance carriers more than twice in the last five years</td>
</tr>
<tr>
<td>⚠️</td>
<td>The group is not based on a specific employer/employee relationship</td>
</tr>
</tbody>
</table>

In addition, we cannot accept the following organizations:

- Associations
- Fraternal organizations
- Dental labs, clinics and offices
- Any group involving a trust instrument, such as Multiple Employer Trusts
- Unions (Taft-Hartley Trusts), where benefits and rates are subject to labor management negotiations
- Voluntary arrangements such as cafeteria or Section 125 plans

[^1]: Standard Select Group Life with AD&D, LTD and STD insurance products are not available in New York.
[^2]: Colorado, Hawaii, Michigan and Pennsylvania require a greater number of eligible employees for an employer to be eligible for coverage.
Choose From Three Flexible Dental Plans

Standard Select Optima Care℠ plan offers the most generous benefits in terms of frequency of procedures, expense classifications and coinsurance schedule.

Standard Select Banner Dental Care℠ plan is priced 11 percent less than the Optima Care plan. It balances cost and quality care by covering essential procedures to maintain oral health while controlling expenses through procedure limitations.

Standard Select PPO Max plan is priced 28 percent below the Banner Dental Care plan and has the same procedure placement and frequency limits, while also using the dental network negotiated fee amounts for the maximum claim allowance when members visit out-of-network providers. This plan is only offered in areas where network provider density is high enough to maximize network usage, and minimize potential network dissatisfaction among insured members.

All three Dental plans share the same key elements:

• They pay 100 percent of Type 1 (preventive) expenses, 80 percent of Type 2 (basic) expenses and 50 percent of Type 3 (major) expenses, after the $50 per member calendar year deductible is satisfied for Type 2 and Type 3 expenses

• The maximum deductible applied per family is $150 per calendar year

• A choice of a $1,000 or $1,500 maximum benefit amount, per calendar year

All three plans include the Max Builder℠ benefit and a one-year initial rate guarantee (an initial two-year rate guarantee is available when Standard Select Dental coverage is purchased with two or more other lines of coverage from The Standard). In addition, the following options are available:

• Orthodontia coverage
• Eye care coverage
• Dependents coverage

Max Builder Benefit

The Max Builder benefit allows employers to reward insured members who care for their teeth but use only a portion of their annual benefit maximum. When members see a dentist yearly and use less than half of their annual benefit maximum, they receive an increase in their annual benefit maximum for the next plan year. The Max Builder benefit allows members to save their benefits to cover future dental procedures, potentially reducing their out-of-pocket expenses.

Nationwide Network

Our Dental insurance includes the advantages of the Ameritas dental network -- one of the largest in the nation, with more than 348,000 providers. Every three years, providers in the network undergo a review, ensuring that your employees have access to the highest-quality dental care possible.

With all three Standard Select Dental plans, the 100/80/50 coinsurance remains the same whether the member goes to an in-network or out-of-network provider. The benefit of seeing an in-network dentist is the lower negotiated fees agreed to by those providers. For employers, the contracted fees of network dentists may ultimately result in lower insurance costs.

Members can locate and contact nearby providers using the Ameritas Provider Locator app for iPhone and Android devices. Search results include specialty, office hours and languages spoken.

3 There is no deductible for Type 1 expenses. The Type 1 expenses in the Banner Dental Care and PPO Max plans are different than the Type 1 expenses in the Optima Care plan.
Orthodontia Benefit

The Standard understands that orthodontics – the treatment of an improper bite or malocclusion – is an important aspect of general dental care. That’s why the following orthodontia coverage is an optional benefit for all three plans:

- Requires a minimum of five enrolled employees on the effective date of coverage and at each renewal
- 12-month waiting period
- Takeover coverage is not available
- Provides a $1,000 lifetime maximum, 50 percent coinsurance, and no deductible

Eye Care Benefit

You can also enhance your benefits by adding affordable vision coverage to any Dental plan. Features include:

- A $20 calendar-year deductible for exam and materials
- Frequency options for Exam-Lenses-Frames of 12-12-24 months. Lenses/Frame (glasses) and contacts are not both available in the same 12- or 24-month period
- A plan design that covers up to
  - $50 for an annual eye exam
  - $40 for single vision lenses
  - $60 for bifocal lenses
  - $75 for trifocal lenses
  - $80 for progressive lenses
  - $80 for lenticular lenses
  - $80 for frames
  - $100 for contact lenses

Benefits for eligible members:

- Choice of any eye care provider
- Employees pay for all services, then submit a claim to The Standard for reimbursement
- Claims are reimbursed based on a schedule of benefits – your employees know precisely how much is covered ahead of time

Pre-treatment Estimate

The pre-treatment estimate will tell the member what percentage of the charges for the proposed dental work will be covered by insurance. The member can then work out the necessary financial arrangements or postpone treatments to a later date.

Coordination of Benefits

This plan is not intended to duplicate benefits received from other group or employer-sponsored plans. Where such benefits are payable, the benefits payable under this plan and the other plan will be coordinated so that no more than 100 percent of the allowable charges are reimbursed.

Online Administration Tools

Designed to save you time and simplify your plan administration, our online administration tools are a fast, easy and secure way to administer your plan. These online services are available at no additional cost to groups with 10 or more insured members.

Plan administrators are able to perform a number of functions online, including: enrolling members, changing enrollment records, creating and paying premium bills, viewing eligibility reports and viewing policy, certificate and amendment documents.

Electronic Funds Transfer (EFT)

Pay your monthly or quarterly premiums with EFT, available to all Dental groups. After you sign up for EFT, The Standard will automatically debit your business bank account for the premium amount due.
**Which Standard Select Plan Best Fits Your Business?**

All three Dental plans share the same key elements. They pay 100 percent of Type 1 (preventive) expenses, 80 percent of Type 2 (basic) expenses and 50 percent of Type 3 (major) expenses, after the $50 per insured member per calendar year deductible is satisfied for Type 2 and Type 3 expenses. The maximum deductible applied per family is $150 per calendar year. All plans also are available with a $1,000 or $1,500 maximum benefit amount, per calendar year.

<table>
<thead>
<tr>
<th></th>
<th>Standard Select Optima Care&lt;sup&gt;SM&lt;/sup&gt;</th>
<th>Standard Select Banner Dental Care&lt;sup&gt;SM&lt;/sup&gt;</th>
<th>Standard Select PPO Max&lt;sup&gt;SM&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Usual &amp; Customary Charges</td>
<td>U&amp;C 90th Percentile</td>
<td>U&amp;C 90th Percentile</td>
<td>Negotiated fee schedule</td>
</tr>
<tr>
<td></td>
<td><strong>Type 1 Dental Expense Category</strong></td>
<td><strong>Type 1 Dental Expense Category</strong></td>
<td><strong>Type 1 Dental Expense Category</strong></td>
</tr>
<tr>
<td>Expense Reimbursement&lt;sup&gt;1&lt;/sup&gt;</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Routine Oral Exams</td>
<td>Twice per benefit period</td>
<td>Twice per benefit period</td>
<td>Twice per benefit period</td>
</tr>
<tr>
<td>Full Mouth or Panoramic X-rays</td>
<td>Once every 3 years</td>
<td>Once every 5 years</td>
<td>Once every 5 years</td>
</tr>
<tr>
<td></td>
<td>Covered as a Type 2 Expense</td>
<td>Covered as a Type 2 Expense</td>
<td>Covered as a Type 2 Expense</td>
</tr>
<tr>
<td>Bitewing X-rays</td>
<td>2 sets per benefit period</td>
<td>2 sets per benefit period</td>
<td>2 sets per benefit period</td>
</tr>
<tr>
<td></td>
<td>Covered as a Type 2 Expense</td>
<td>Covered as a Type 2 Expense</td>
<td>Covered as a Type 2 Expense</td>
</tr>
<tr>
<td>Palliative (emergency) Treatment</td>
<td>Covered</td>
<td>Covered as a Type 2 Expense</td>
<td>Covered as a Type 2 Expense</td>
</tr>
<tr>
<td>Sealtants</td>
<td>Covered through age 16</td>
<td>Covered through age 13</td>
<td>Covered through age 13</td>
</tr>
<tr>
<td></td>
<td>Covered as a Type 2 Expense</td>
<td>Covered as a Type 2 Expense</td>
<td>Covered as a Type 2 Expense</td>
</tr>
<tr>
<td>Fluoride Treatments</td>
<td>Covered through age 18</td>
<td>Covered through age 13</td>
<td>Covered through age 13</td>
</tr>
<tr>
<td>Regular Cleanings (prophylaxis)</td>
<td>2 per benefit period</td>
<td>2 per benefit period</td>
<td>2 per benefit period</td>
</tr>
<tr>
<td></td>
<td>(regular and periodontal cleanings, combined)</td>
<td>(regular and periodontal cleanings, combined)</td>
<td>(regular and periodontal cleanings, combined)</td>
</tr>
</tbody>
</table>

continued on next page
<table>
<thead>
<tr>
<th></th>
<th>Standard Select Optima Care&lt;sup&gt;SM&lt;/sup&gt;</th>
<th>Standard Select Banner Dental Care&lt;sup&gt;SM&lt;/sup&gt;</th>
<th>Standard Select PPO Max&lt;sup&gt;2&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Usual &amp; Customary Charges</td>
<td>U&amp;C 90th Percentile</td>
<td>U&amp;C 90th Percentile</td>
<td>Negotiated fee schedule</td>
</tr>
<tr>
<td><strong>Type 2 (basic) Dental Expense Category</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expense Reimbursement&lt;sup&gt;1&lt;/sup&gt;</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Simple Extraction</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Amalgam/Composite Restorations (fillings)</td>
<td>Covered</td>
<td>Covered as a Type 3 Expense</td>
<td>Covered as a Type 3 Expense</td>
</tr>
<tr>
<td>General Anesthetics</td>
<td>Covered</td>
<td>Covered as a Type 3 Expense</td>
<td>Covered as a Type 3 Expense</td>
</tr>
<tr>
<td>Covered Oral Surgery</td>
<td>Covered</td>
<td>Covered as a Type 3 Expense</td>
<td>Covered as a Type 3 Expense</td>
</tr>
<tr>
<td>Endodontic Services (root canals)</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Periodontal Cleanings (periodontal maintenance)</td>
<td>2 per benefit period (regular and periodontal cleanings, combined)</td>
<td>2 per benefit period (regular and periodontal cleanings, combined)</td>
<td>2 per benefit period (regular and periodontal cleanings, combined)</td>
</tr>
<tr>
<td><strong>Type 3 (major) Dental Expense Category</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expense Reimbursement&lt;sup&gt;1&lt;/sup&gt;</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Crowns, Inlays and Onlays, Bridges, Dentures, Partial Dentures, and Prosthetic Replacements</td>
<td>Once every 5 years</td>
<td>Once every 10 years</td>
<td>Once every 10 years</td>
</tr>
<tr>
<td>Recementing Crowns, Bridges, Inlays and Onlays</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td><strong>Additional Benefits and Coverage</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Max Builder&lt;sup&gt;SM&lt;/sup&gt; Benefit</td>
<td>Included</td>
<td>Included</td>
<td>Included</td>
</tr>
<tr>
<td>Orthodontia</td>
<td>Available</td>
<td>Available</td>
<td>Available</td>
</tr>
<tr>
<td>Eye Care</td>
<td>Available</td>
<td>Available</td>
<td>Available</td>
</tr>
</tbody>
</table>

Any discrepancies between this comparison and the proposal sheet will be ruled by the proposal sheet.

1 Unless otherwise noted in the chart above.

2 Standard Select PPO Max is offered only in areas where provider density is high enough to maximize network usage.
Employee and Dependent Eligibility

Coverage is available to all active employees who meet evidence of insurability requirements, are actively at work at least 30 hours each week, and meet the required eligibility waiting period as shown in the Dental proposal. Temporary and seasonal employees, full-time members of the armed forces of any country, leased employees, independent contractors and non-payroll workers are not eligible for coverage.

Current employees will become eligible on the date the Dental coverage is effective. New employees hired after that date are eligible on their date of hire and will qualify for the insurance upon completion of the eligibility period selected by the employer.

There is a one-year waiting period on Type 3 (major) expenses. The one-year wait is waived for eligible members on the effective date if the prior plan has been in force for at least two years. A copy of the current carrier’s billing and certificate booklet is required. New hires after the policy effective date will serve a one-year waiting period before Type 3 (major) expenses will be reimbursed.

Eligible dependents include the insured employee’s spouse and unmarried child(ren) prior to their 19th birthday who do not work for the employer.

In addition, unmarried child(ren) from their 19th birthday to the day before their 24th birthday are eligible if they are full-time students attending an accredited educational institution and primarily dependent upon the employee for support and maintenance. Dependent ages may vary based on state legislation. Call 800.547.9515 to verify eligibility.
Contributory and Noncontributory Plans

Group Dental plans may be written on a noncontributory or contributory basis. With a noncontributory plan, the employer pays the entire premium. Employees do not contribute toward the cost of the insurance. All eligible employees must participate in a noncontributory plan. However, employees may opt out if they are covered under another group Dental policy.

With a contributory plan, employees pay part of the cost of insurance. The Standard requires the employer to contribute at least 50 percent of the premium for each coverage and employees may choose whether to participate in the plan. Employees must enroll within 31 days after becoming eligible. If an employee or their dependent(s) enroll more than 31 days after becoming eligible, the employee and/or the dependent(s) will be considered late entrants and will be eligible only for limited benefits for one year from the effective date.

With a contributory plan, eligibility for coverage is contingent on a minimum number of eligible employees participating in the plan, as shown below.

<table>
<thead>
<tr>
<th>Total Number of Eligible Employees</th>
<th>Employee Participation Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>3 or 4</td>
<td>3</td>
</tr>
<tr>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>7 or 8</td>
<td>6</td>
</tr>
<tr>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>10 or more</td>
<td>The greater of 8 eligible employees or 75 percent of eligible employees</td>
</tr>
</tbody>
</table>

There are two exceptions to the participation requirements:

1) If a husband and wife are both employed by the same employer, either the husband or wife may elect to be insured as a dependent rather than as an employee.

2) Employers that fall below the two-insured employees level have 90 days to bring the number up to the required level. If after 90 days the company still has fewer than the required number of employees insured, that company’s coverage will be terminated.
Employee/Dependent Coverage Effective Dates

For noncontributory plans, coverage is effective on the first day of the month following the date that an employee or dependent becomes eligible.

For contributory plans, coverage is effective on the later of:
- The date the employee or dependent becomes eligible
- The date the employee applies for coverage under the plan, if application is made within 31 days of becoming eligible

Late Entrant Penalty

If application for contributory Dental insurance is made more than 31 days after the date of eligibility, the applicant will be subject to the late entrant penalty. The late entrant penalty means that during the first 12 months after insurance becomes effective, the insured will be covered only for exams, regular cleanings and fluoride (if applicable).

Benefit Waiting Period

This 12-month wait may be waived if the following Takeover Provisions are met:
- The employer’s prior group dental plan covered Type 3 expenses
- The prior plan was in effect continuously for at least 24 months (time covered under a pre-paid plan, capitation plan, dental maintenance organization (DMO) plan or a discount dental plan does not count)
- The new Standard Select plan effective date immediately follows the termination date of the prior plan with no gaps in coverage
- The following evidence of prior coverage has been submitted:
  - a copy of the previous group insurance carrier’s most recent invoice
  - a certificate or letter of acceptance from the previous group insurance carrier showing the policy effective date
  - the termination date of the prior group dental plan

Limitations

Standard Select Dental plans have limitations, exclusions, reductions of benefits and terms under which the policy may be continued in force or discontinued. Please consult the proposal accompanying this booklet for costs and complete details of the proposed coverage.
Your Proposed Dental Plan

The Standard appreciates the opportunity to provide a proposal to you for Standard Select Group Dental insurance coverage. This booklet and the dental proposal together outline the basic features of your proposed Dental plan. These documents are not a contract.

Establishing group Dental insurance coverage with The Standard requires your completed, signed application for group insurance and our acceptance of it. When we approve your application, we will issue you a group policy containing our customary language. It will not duplicate the language of any existing policies you may have.

Your group policy with The Standard will contain provisions, exclusions, limitations and defined terms not described in this booklet or your dental proposal. If any discrepancies exist between your Dental proposal, the group policy and this booklet, the group policy will control.

The group policy will become effective on the date determined by The Standard. This date will be clearly stated on the policy. We will issue certificates of insurance that describe the coverage in detail. These are for you to distribute to your insured employees.

The proposed premium rate and plan design for your dental coverage are based on the underwriting data we received from you. We will determine final premium rates and plan provisions based on:

- State law
- Policyholder contributions
- The composition of the group of employees you wish to insure
- Our current underwriting rules and practices

The proposal will expire on the date shown in your dental proposal.

Thank you for considering The Standard for your Dental insurance needs. If you have questions or need additional information, please contact your insurance advisor or your Employee Benefits Consultant.

To learn more about The Standard's products for small businesses, contact your insurance advisor, call the Employee Benefits Sales and Service Office for your area at 800.633.8575 or visit us at www.standard.com.

The Standard is a marketing name for StanCorp Financial Group, Inc., and subsidiaries. Insurance products are offered by Standard Insurance Company of 1100 SW Sixth Avenue, Portland, Oregon, in all states except New York, where insurance products are offered by The Standard Life Insurance Company of 360 Hamilton Avenue, Suite 210, White Plains, New York. Product features and availability vary by state and company, and are solely the responsibility of each subsidiary. Each company is solely responsible for its own financial condition. The Standard is licensed to solicit insurance business in all states except New York. The Standard Life Insurance Company of New York is licensed to solicit insurance business in only the state of New York.

Group Dental Insurance underwritten by Standard Insurance Company is provided under policy form number: SIC 9000 Rev. 04-13; dates may vary by state.

Group Dental Insurance underwritten by The Standard Life Insurance Company of New York is provided under policy form number: SNY 9000 Rev. 04-13.

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