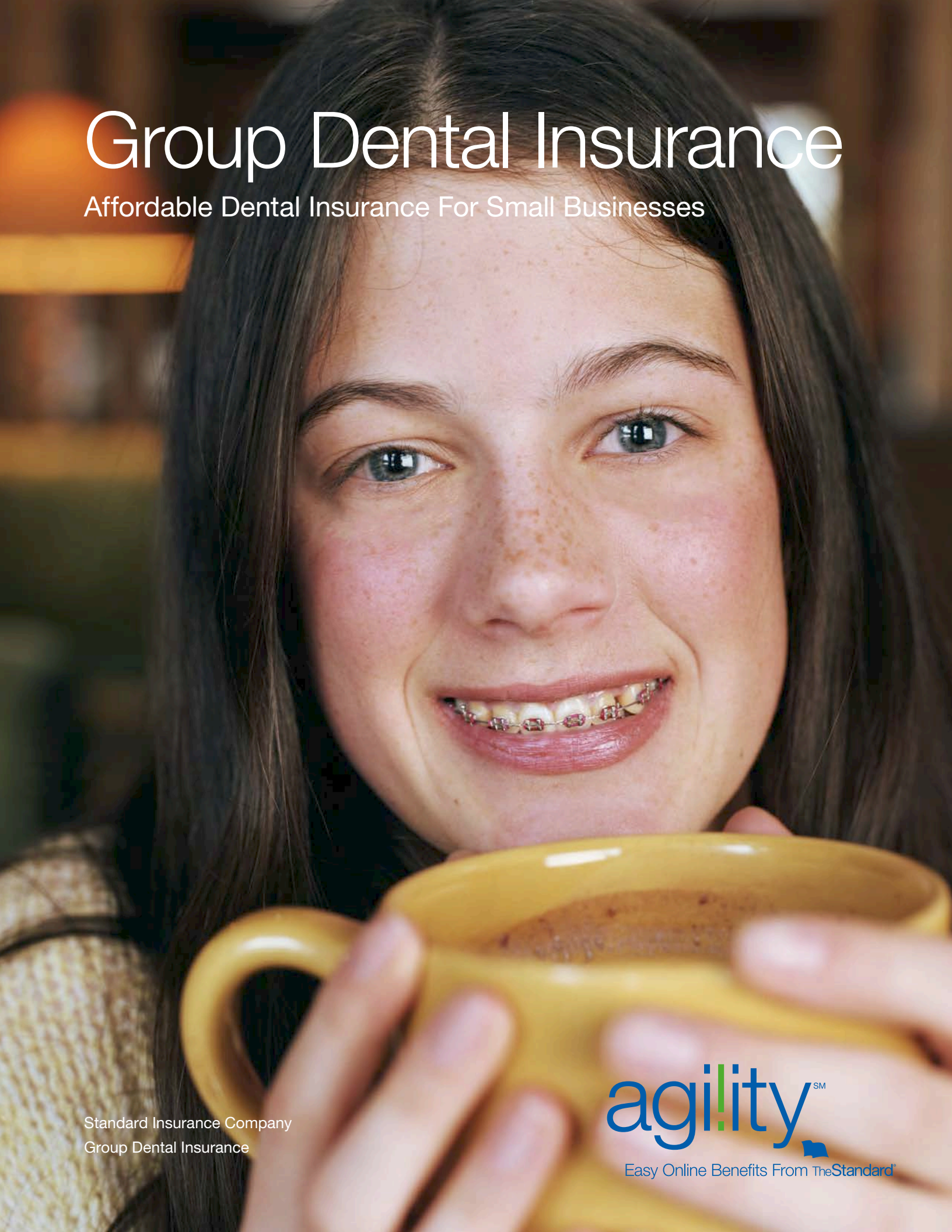
Group Dental Insurance

Affordable Dental Insurance For Small Businesses



Standard Insurance Company
Group Dental Insurance

agility℠
Easy Online Benefits From TheStandard®



Meeting The Needs Of Small Businesses

Finding employee benefits that meet the needs of a small business can be challenging, but Standard Insurance Company offers a solution. The Standard's small business line of group insurance products is streamlined, competitively priced and an easy way for small businesses to provide benefits to their employees.

This document discusses our group Dental coverage.

Is Dental Insurance Right For All Small Businesses?

We specifically designed our Dental coverage for small businesses with two or more eligible employees.[1]

To be eligible, a small business must:

- Be financially sound and provide stable, year-round employment
- Be structured as a corporation, partnership or proprietorship
- Have an employer/employee relationship
- Have a central office for billing and insurance record maintenance
- Have access to a computer

Unfortunately, not all small businesses will qualify for coverage. In general, companies are not eligible for coverage if:

- More than 50 percent of the employees are related
- They are an association, multiple employer trust or group not based on a specific employer/employee relationship

1 Some states may require a greater number of eligible employees for an employer to be eligible for coverage.



Comparison of Group Dental Options

The Standard offers three Dental plan options to meet your needs and those of your employees.

Annual Maximum Benefit Amount[2]	$1,000 or $1,500 or $2,000
Deductible	- Type 1 Procedures: $50 (option to offer no deductible) - Type 2 and Type 3 Procedures: $50
Maximum Family Deductible	$150
Additional Benefits and Coverage	
Max Builder℠ Benefit	Included
PPO Bonus[3]	Included
Orthodontia Option[4]	$1,000 lifetime max, $0 deductible, 50% co-pay

Enhanced Treatment Schedule Type 1 Procedures | Coinsurance: 80% (Good) or 100% (Better and Best[5])	
Routine Oral Exams	Twice per benefit period
Regular Cleanings	Twice per benefit period
Fluoride Treatments	Covered through age 13
Space Maintainers	Covered
Bitewing X-Rays	2 sets per benefit period
Full Mouth or Panoramic X-Rays	Once every 5 years
Periapical X-Rays	Covered
Sealants	Covered through age 13
Type 2 Procedures | Coinsurance: 80%	
Amalgam/Composite Restoration (Fillings)	Covered
Stainless Steel Crowns	Once every year
Endodontics Services (surgical and nonsurgical)	Covered
Surgical and non-surgical extractions	Covered
Other Oral Surgery	Covered
Periodontics (surgical and nonsurgical)	Covered
General Anesthetics with Covered Oral Surgery Expense	Covered
Type 3 Procedures | Coinsurance: 50%	
Denture Repair	Covered
Prosthodontics (Fixed Bridge, Removable Complete/Partial Dentures)	Once every 10 years
Onlays	Covered
Crowns	(1 in 10 years per tooth)
Crown repair	Covered

2 Choice of Annual Maximum Benefit Amount not available in all areas. In some areas, amount is determined by choice of plan.

3 The PPO Bonus is not available in all areas.

4 The Orthodontia Option is available with 10 eligible employees, minimum 5 enrolled, with 50% or more employer contribution.

5 In New Jersey only the Best Plan is available.

Affordable Dental Coverage: Plan Features

Finding a balance between quality Dental coverage and affordable premiums is key for many small employers. With The Standard's group Dental coverage, you can find the right mix of cost-effective dental benefits for your employees.

Our Dental plans are available in Good, Better and Best[6] options. Key features include:

- Type 1 Procedures: The plan pays 80 percent (with Good option) or 100 percent (with Better and Best options)
- Type 2 Procedures: The plan pays 80 percent
- Type 3 Procedures: The plan pays 50 percent
- Maximum deductible: $150 per family per calendar year
- Annual maximum benefit amount: $1,000, $1,500 or $2,000 (choice of maximum amount is not available in all areas.

Your Dental coverage comes with a one-year initial rate guarantee (a two-year initial rate guarantee is available when The Standard's Dental coverage is purchased with two or more lines of coverage from The Standard).[7] In addition, the following options are available:

- Orthodontia coverage
- Dependents coverage

Passive PPO: The Power Of A Nationwide PPO

The Passive PPO (Participating Provider Organization) enables employees who are covered by any of The Standard's Dental policies to enjoy the benefits of a powerful network of member dentists.[8]

The Passive PPO can reduce out-of-pocket expenses for employees and control Dental insurance costs for employers. The PPO coverage is provided on a passive basis, which means that your employees' coinsurance percentage remains the same whether they go to an in-network or out-of-network provider. For the employee, the benefit of seeing a PPO dentist is the lower negotiated fees that those providers have agreed to. For employers, the contracted fees of PPO member dentists may ultimately result in lower insurance costs.

Max Builder Benefit

The Max Builder benefit allows employers to reward insured employees who care for their teeth but use only a portion of their annual benefit maximum. When employees 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 insured employees to save their benefits to cover future dental procedures, potentially reducing their out-of-pocket expenses. For employees who qualify for a Max Builder benefit maximum increase, they can earn a bigger increase in their benefits maximum by receiving a PPO Bonus for visiting an in-network dentist.

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 we've made orthodontia coverage an available benefit for adults and children on all three plans:

- Requires a minimum of 10 eligible employees with at least 5 enrolled on the effective date of coverage and at each renewal
- Consecutive 12-month waiting period
- Takeover coverage is not available
- Provides a $1,000 lifetime maximum, 50 percent coinsurance and no deductible
- Requires a minimum of 50% employer contribution

Information About Your Coverage

Pre-treatment Estimate

Before having dental work done, a member can ask his or her dentist to request a pre-treatment estimate of the benefit from The Standard. The estimate will provide information on how much of the proposed dental work will be covered by insurance. The member can then work out the necessary financial arrangements or postpone some work to a later date.

6 In New Jersey only the Best Plan is available.

7 In Florida, only a one-year initial rate guarantee is available.

8 A Passive PPO is not available in all areas.

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.

Employee And Dependent Eligibility

Coverage is available to all employees who are actively at work at least 30 hours each week and meet the required eligibility waiting period as shown in the Dental Proposal Summary. Employees residing in New Mexico, 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.

Employers may choose the minimum number of hours that the eligible employee must regularly work each week at the employer's usual place of business in order to be a member.

An employee is eligible for insurance on the effective date of the employer's coverage under the group policy if the employee is a member on that date.

New hires are eligible once they serve the eligibility waiting period. You may choose an eligibility waiting period of date of hire, 30, 60, 90 or 180[9] days for your group insurance plan. In this event, an employee becomes eligible for insurance on the first day of the calendar month coinciding with, or next following, the specified days as a member.

Eligible dependents include the insured employee's spouse[10] and child(ren)[11] prior to their 26th birthday. However, some states have legislation that extends coverage beyond this age limit. Additionally, coverage may continue beyond the specified age if the dependent is totally disabled.
Call 855.737.4575 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. With a contributory plan, employees pay all or part of the cost of insurance. 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 contributory and noncontributory plans, eligibility for coverage is contingent on a minimum number of eligible employees participating in the plan. The minimum number of participating members is generally two, but some states may require a greater number of eligible employees.

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 the application is made within 31 days of becoming eligible

Late Entrant Penalty

If an 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

The waiting period for Type 3 expenses is 12 months. This 12-month wait may be waived if the employer had current group dental coverage in effect immediately prior to The Standard's new plan effective date.

9 Eligibility Waiting Period options may vary by state.

10 Spouse may include a civil union partner. Eligibility not available in all states. Contact your insurance broker for details.

11 Child may include a child of a civil union. Eligibility not available in all states. Contact your insurance broker for details.



Non-covered Expenses

Benefits will not be payable for expenses incurred for any of the following:

- Any procedure except exams, cleaning and fluoride applications (if applicable) for the first 12 months when an employee or dependent becomes classified as a late entrant. An employee or dependent who does not enroll within 31 days from the date the person qualifies for the insurance, or who elects to become covered again after canceling a premium contribution agreement, will be classified as a late entrant.
- A treatment which is for cosmetic purposes.
- Replacement of any prosthetic appliance, crown, inlay or onlay restoration, or fixed partial denture within ten years of the date of the last placement of these items. However, if a replacement is required because of an accidental bodily injury sustained while the person is covered, it will be a covered expense.
- Initial placement of any dental prosthesis or prosthetic crown unless such placement is needed because of the extraction of one or more teeth (excluding wisdom teeth) while the plan participant is covered under the dental expense benefit. Any such dental prosthesis or prosthetic crown must include the replacement of the extracted tooth or teeth.
- Any procedure begun before the plan participant was covered under the dental expense benefit
- Any procedure begun after the participant's insurance under the dental expense benefit terminates or any prosthetic dental appliances installed or delivered more than 90 days after the participant's insurance under the dental expense benefit terminates
- Replacement of lost or stolen appliances
- Appliances, restorations or procedures to:
  - Alter vertical dimension
  - Restore or maintain occlusion
  - Splint or replace tooth structure lost because of abrasion or attrition
- Any procedure that is not shown on the Table of Dental Procedures in your policy
- Orthodontic treatment, if the employer chooses not to include orthodontia
- Any treatment for which the plan participant is entitled to benefits under any workers' compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit
- Charges for which the plan participant is not liable or which would not have been made had no insurance been in force
- Services that are not required for necessary care and treatment or are not within the generally accepted parameters of care
- Treatment needed as a result of war or any act of war, declared or not
- Major procedures in the first 12 months that the plan participant is covered under the dental expense benefit if no coverage was in force prior to The Standard's new plan effective date
- Orthodontic procedures before the plan participant has been covered under the orthodontic expense benefits for at least 12 consecutive months
- Orthodontic procedures in any quarter of a prescribed orthodontic treatment program if the participant was not covered under the orthodontic expense benefits for the entire quarter
- Orthodontic procedures after the participant's insurance under the orthodontic expense benefits terminates

Limitations

The Standard's Dental plans have exclusions, limitations, reduction of benefits and terms under which the policy may be continued in force or discontinued. For costs, limitations and complete details of the coverage, consult the Dental proposal accompanying this booklet, contact your insurance advisor or Agility from The Standard at 855.737.4575.

Your Policy

This document outlines the basic features of The Standard's Dental insurance plans, some of which may eventually be contained in your proposal. Both of these documents are not a contract, and they are not part of any contract that may be issued.

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

Establishing group Dental insurance with The Standard requires your acceptance of coverage by electronic signature and the promise to pay premiums in the accordance of the terms of the group policy. Once we receive your electronic signature, we will issue you a group policy containing our customary language. Simply put, it's the policy that makes our long-term partnership official.

Your Premium Rate

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

- State law
- 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 the Dental Proposal Summary.

When Does Coverage Begin?

Your coverage under the group policy will become effective on the date determined by The Standard, which will be clearly stated in your policy. We will also supply you with identification cards and certificates of insurance, describing the coverage in detail, for you to deliver to your insured employees.



More Details

Information To Help You Learn More About The Standard's Dental Plans

When Does Coverage End?

In general, group insurance for an employee ends automatically on the earliest of the following:

- The date the last period ends for which a premium contribution is received
- The date the employer's coverage under the group policy terminates
- The date employment terminates
- The date the employee fails to meet the definition of a member

If Group Dental insurance coverage is selected for a spouse or child, in addition to the above, coverage for an insured dependent automatically ends on the earliest of the following:

- The date the group insurance ends for the insured employee
- For a spouse, the date of divorce
- For a dependent, the date the individual ceases to meet the definition of dependent in the group policy
- For a child who is disabled, 31 days after The Standard requests proof of disability if proof is not given

Employer And Group Policy Termination

Employers may terminate their coverage under the group policy by providing The Standard with written notice. An employer's coverage under the group policy will automatically terminate if premium is not received by the end of the grace period shown in the group policy.

The Standard may terminate the employer's coverage under the group policy if the number of employees insured is less than the minimum participation requirement as shown in the Dental Proposal Summary. The Standard may also terminate the employer's coverage under the group policy if we determine the employer has failed to promptly furnish any necessary information requested by us or has failed to perform any other obligations relating to coverage under the group policy.



About The Standard

Founded in Portland, Oregon in 1906, The Standard is a nationally recognized provider of group employee benefits and Individual Disability insurance.

Our first group policy, written in 1951 and still in force today, stands as a testament to our commitment to building long-term relationships. We always strive to do what's right – for our policyholders and their employees. This dedication has resulted in a national reputation for quality products, superior service and industry expertise.

To learn more about Group Dental Insurance from The Standard, contact your insurance advisor or the Employee Benefits Sales and Service Office for your area at 800.633.8575 or visit us at **www.standard.com**.

Standard Insurance Company | 1100 SW Sixth Avenue, Portland, OR 97204 | 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. Product features and availability vary by state and are solely the responsibility of Standard Insurance Company.