

THE STANDARD INSURANCE – CAMCO BENEFIT SERVICES

HIGH PLAN *Dental Summary Sheet*

800 845 4669

Dental HIGH Plan Summary – COLORADO-MONTANA-WYOMING Effective May 1, 2014 – October 31, 2015

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

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

| Type 1 – Covered 100% | Type 2 – Covered 80% | Type 3 – Covered 50% |
|--|---|--|
| <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> Restorative Amalgams Restorative Composites Endodontics (nonsurgical) Denture Repair Simple Extractions | <ul style="list-style-type: none"> 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-Weekly Rates | Monthly Rates |
|-----------------------------------|-----------------|-----------------|
| Employee Only (EE) | \$ 25.00 | \$ 54.17 |
| EE + Spouse | \$ 39.00 | \$ 84.50 |
| EE + Children | \$ 44.00 | \$ 95.33 |
| EE + Spouse & Children | \$ 58.00 | \$125.67 |

Bi-Weekly Rates are based on 26 Pay Periods

Max Builder

The Standard Dental Care 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



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

Camco Benefit Services administrates your account and will be happy to handle all questions and concerns regarding your coverage, premiums and status of your policy. We will gladly advise and give guidance in a friendly and professional manner. Contact us at **800.845.4669**.

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 800 547 9515 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.

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.

Late Entrant Provision

We strongly encourage you to sign up for coverage when you are initially eligible. If you choose not to sign up during this initial enrollment period, you will become a late entrant. Late entrants will be eligible for only exams, cleanings, and fluoride applications for the first 12 months they are covered.

Section 125

This plan is provided as part of the Policyholder's Section 125 Plan. Each employee has the option under the Section 125 Plan of participating or not participating in this plan. If an employee does not elect to participate when initially eligible, he/she may elect to participate at the Policyholder's next Annual Election Period.

This form is a benefit highlight, not a certificate of insurance.

By enrolling on this plan, member is agreeing to a one year commitment. Should member terminate coverage prior to their one-year anniversary, a \$100.00 fee will be imposed.

All terminations must be made to CAMCO BENEFIT SERVICES and submitted in writing either by FAX, Email or Postal Mail.

FAX: 360-438-6256

MAIL: PO BOX 5667, Lacey, WA 98503

EMAIL OR SIGN UP ONLINE AT: www.camcobenefits.com

PHONE: 800-845-4669



FAX (360) 438-6256
www.camcobenefits.com

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 Number(s) 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 <input type="checkbox"/> Low Dental Plan <input type="checkbox"/> High Dental Plan <input type="checkbox"/> Orthodontic Dental Plan Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced Coverage requested for <input type="checkbox"/> You, your Spouse and Children <input type="checkbox"/> You and your Spouse <input type="checkbox"/> You only <input type="checkbox"/> You and your Children (no Spouse) Are you covered for dental insurance under another plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Are one or more Dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | |
| | <i>List Dependents to enroll or delete.</i> | | | Sex | Date of Birth | <i>List Dependents to enroll or delete.</i> | | | Sex | Date of Birth |
| | (Last name if different, First, Middle Initial) | | | M | F | (Attach sheet for additional Dependents if needed.) | | | M | F |
| | Spouse | | | | | Child 2 | | | | |
| | Child 1 | | | | | Child 3 | | | | |
| CHANGE | <i>Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.</i> <input type="checkbox"/> Add Dependent <input type="checkbox"/> Delete Dependent <input type="checkbox"/> Name Change Date of add/delete _____ Former name _____ <input type="checkbox"/> Other _____ | | | | | | | | | |
| | 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. | | | | | | | | | |
| SIGNATURE | Member/Employee Signature Required | | | | | | Date (Mo/Day/Yr) | | | |
| | Retain a copy of this form for your records | | | | | | | | | |
| Date of Hire/Rehire | | | | Hrs. Worked Per Wk. | | | | | | |

Camco Benefit Services
800 845 4669

EMAIL OR SIGN UP ONLINE: www.camcobenefits.com

Camco Benefit Services

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 (the 10th of the month) (debit type)

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 active for a period of 12 months from your initial effective date. An Early Termination Fee of \$100 will be assessed for any policy terminated by employee/client prior to completion of their 12-month agreement.

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

Please Mail To:

Camco Benefit Services - PO BOX 5667- Lacey, WA 98503

EMAIL OR SIGN UP ONLINE:

www.CAMCOBENEFITS.COM

CAMCO BENEFIT SERVICES

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