THE STANDARD INSURANCE – CAMCO BENEFIT SERVICES

LOW OPTION PLAN *Dental Summary Sheet* *(800) 845 4669*

Dental Low Option Plan Summary – ALL LOCATIONS BELOW **Eff May 1, 2014 thru Oct 31, 2015**

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

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

Type 1 -100% Covered	**Type 2 – 80% Covered**	**Type 3 – NOT COVERED**
• Routine Exam (1 in 6 months)	• Restorative Amalgams	• Onlays
• Bitewing X-rays (1 in 12 months)	• Restorative Composites	• Crowns (1 in 10 years per tooth)
• Full Mouth/Panoramic X-rays (1 in 5 years)	• Endodontics (nonsurgical)	• Crown Repair
• Periapical X-rays	• Denture Repair	• Endodontics (surgical)
• Cleaning (1 in 6 months)	• Simple Extractions	• Periodontics (nonsurgical)
• Fluoride for Children 13 and under (1 per benefit period)		• Periodontics (surgical)
• Sealants (age 13 and under)		• Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 10 years)
• Space Maintainers		• Complex Extractions
		• Anesthesia

Bi-Weekly Rates are based on 26 Pay Periods per Year

LOW PLAN: WA, OR & ID	**Bi-Weekly**	**Monthly**
Member Only	$ 30.20	$ 65.43
Member + Spouse	$ 46.38	$ 100.49
Member + Children	$ 51.30	$ 111.15
Member + Spouse + Children	$ 68.30	$ 147.98

LOW PLAN: CO, MT & WY	**Bi-Weekly**	**Monthly**
Member Only	$ 20.42	$ 44.24
Member + Spouse	$ 30.84	$ 66.82
Member + Children	$ 36.02	$ 78.04
Member + Spouse + Children	$ 46.38	$ 100.49

(Continued on next page)

The Standard Insurance Co. – CAMCO BENEFIT SERVICES

Dental Highlight Sheet – LOW OPTION PLAN

LOW PLAN: ALASKA	Bi-Weekly	Monthly
Member Only	$ 29.08	$ 63.01
Member + Spouse	$ 46.98	$ 101.79
Member + Children	$ 46.98	$ 101.79
Member + Family	$ 74.70	$ 161.85

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.

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: info@camcobenefits.com

camco benefit services

FAX (360) 438-6256
www.camcobenefitservices.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 ☐ 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. I understand that my premium amount will change if my coverage changes.

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

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

www.CAMCOBENEFITSERVICES.COM

CAMCO BENEFIT SERVICES
800-845-4669
FAX 360-438-6256

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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)

Retain a copy of this form for your records

Date of Hire/Rehire	Hrs. Worked Per Wk.

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800 845 4669

EMAIL OR SIGN UP ONLINE: www.camcobenefits.com

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