

<i>SERFF Tracking Number:</i>	<i>AMFA-126071553</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Standard Insurance Company</i>	<i>State Tracking Number:</i>	<i>41778</i>
<i>Company Tracking Number:</i>	<i>SIC - SENSIBLE CHOICE</i>		
<i>TOI:</i>	<i>H10G Group Health - Dental</i>	<i>Sub-TOI:</i>	<i>H10G.000 Health - Dental</i>
<i>Product Name:</i>	<i>SIC - Sensible Choice</i>		
<i>Project Name/Number:</i>	<i>Sensible Choice/Sensible Choice</i>		

Filing at a Glance

Company: Standard Insurance Company

Product Name: SIC - Sensible Choice

TOI: H10G Group Health - Dental

Sub-TOI: H10G.000 Health - Dental

Filing Type: Form

SERFF Tr Num: AMFA-126071553 State: ArkansasLH

SERFF Status: Closed

State Tr Num: 41778

Co Tr Num: SIC - SENSIBLE
CHOICE

State Status: Approved-Closed

Co Status:

Reviewer(s): Rosalind Minor

Author: Janis Landon

Disposition Date: 03/16/2009

Date Submitted: 03/12/2009

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Sensible Choice

Project Number: Sensible Choice

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 03/16/2009

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Employer

Explanation for Other Group Market Type:

State Status Changed: 03/16/2009

Corresponding Filing Tracking Number:

Deemer Date:

Filing Description:

RE: Standard Insurance Company

NAIC No.: 000-69019

FEIN No.: 93-0242990

Form Nos: 9040 DR Rev. 03-09 – Schedule of Benefits (Outline of Coverage)

9232 DR Rev. 03-09 – Table of Dental Procedures

SERFF Tracking Number: AMFA-126071553 *State:* Arkansas
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Janis Landon
 Senior Contract Analyst
 Authorized Filing Agent for Standard Life Insurance Company

Company and Contact

Filing Contact Information

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 Lincoln, NE 68501-1889 (402) 467-7956[FAX]

Filing Company Information

Standard Insurance Company	CoCode: 69019	State of Domicile: Oregon
900 SW Fifth Avenue	Group Code: -99	Company Type:
Portland, OR 97204-1235	Group Name:	State ID Number:
(800) 745-6665 ext. [Phone]	FEIN Number: 93-0242990	

Filing Fees

Fee Required? Yes
 Fee Amount: \$40.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Standard Insurance Company	\$40.00	03/12/2009	26362839

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/16/2009	03/16/2009

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Disposition

Disposition Date: 03/16/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AMFA-126071553 *State:* Arkansas
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Table of Dental Procedures	Approved-Closed	Yes

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Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	9040 DR Rev. 03-09	Certificate	Schedule of Benefits	Revised	Replaced Form #: 9040 DR Ed. 01-08 Previous Filing #: 36370	50	9040 DR Rev. 03-09.pdf
Approved-Closed	9232 DR Rev. 03-09	Certificate	Table of Dental Procedures	Revised	Replaced Form #: 9232 DR Ed. 01-08 Previous Filing #: 36370	50	9232 DR Rev. 03-09.pdf

**SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE**

The Insurance for each Insured and each Insured Dependent will be based on the Insured's class shown in this Schedule of Benefits.

<u>Benefit Class</u>	<u>Class Description</u>
Class 1	All Eligible Employees

DENTAL EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

- First Level: The Plan pays [0 - 100]% of the first \$[0-5,000] of [Preventive, Dental and Orthodontic] Covered Expenses [up to the Maximum Amount].
- Second Level: You pay the next \$[25 - 250] of Covered Expenses. (You will not be reimbursed for this \$[25 - 250] of Covered Expenses.)
- Third Level: The Plan will then pay [0 - 100]% of the next \$[0 - 5,000] of any Covered [Dental and Orthodontic] Expenses [subject to the Maximum Amount].
- Fourth Level: The Plan will then pay [0 - 100]% of the next \$[0 - 5,000] of any Covered [Dental and Orthodontic] Expenses [subject to the Maximum Amount].
- Fifth Level: The Plan will then pay [0 - 100]% of the next \$[0 - 5,000] of any Covered [Dental and Orthodontic] Expenses [subject to the Maximum Amount].

[Maximum Amount:

Maximum Amount per Benefit Period Not Applicable]]	\$[500 - 2,500,
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ORTHODONTIC EXPENSE BENEFITS

The Plan pays [25%-50%] of covered Orthodontic Expenses.

Orthodontic Maximum Amount:

Maximum Amount once per Lifetime	\$[500 - 2,500]
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[The Maximum Benefit shown above will be modified for:

- a. any person who was insured for an Orthodontic Expense Benefit under the prior carrier on [December 31, 2007], and
- b. on [January 1, 2008] is both:
 - i. insured under the policy, and
 - ii. currently undergoing a Treatment Program which would have been a covered Treatment Program under the prior carrier had the prior carrier's coverage remained in force.

The modification will result in a reduction of the Maximum Benefit based on:

- a. the normal benefit payable under the policy for the current Treatment Program, minus

b. any amounts to which the person is entitled from the prior carrier for such Treatment Program.

Nothing stated above, however, will act to provide coverage or increase benefits, when the Treatment Program is subject to any limitation shown on 9260.]

TABLE OF DENTAL PROCEDURES

[Closed List option]

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY FOR YOUR PROCEDURE FREQUENCIES AND PROVISIONS.

The attached is a list of dental procedures for which benefits are payable under this section; and is based upon the Current Dental Terminology © American Dental Association. **No benefits are payable for a procedure that is not listed.**

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
 - Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.
- [All of the following are variable.]
- Covered Procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review.
 - Reference to "traumatic injury" under this plan is defined as injury caused by external forces (ie. outside the mouth) and specifically excludes injury caused by internal forces such as bruxism (grinding of teeth).
 - Benefits for replacement prosthetic crown, appliance, or fixed partial denture will be based on the prior placement date. Frequencies which reference Benefit Period will be measured forward within the limits defined as the Benefit Period. All other frequencies will be measured forward from the last covered date of service.
 - X-ray films, periodontal charting and supporting diagnostic data may be requested for our review.
 - We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured.
 - A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

TABLE OF DENTAL PROCEDURES

[Open List option]

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY.

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

COVERED EXPENSES

The following are typical dental expenses covered by the Plan:

- Oral Exams
- Dental Prophylaxis (Cleanings)
- Fluoride Treatments
- Dental X-Rays
- Sealants
- Restorations (Fillings)
- Oral surgery (Extractions)
- Endodontics (Root Canals)
- Periodontics
- Crowns / Bridges / Dentures
- Dental Implants

**COVERED EXPENSES
PREVENTIVE PROCEDURES**

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary
PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

ROUTINE ORAL EVALUATION

D0120 Periodic oral evaluation - established patient.

D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver.

D0150 Comprehensive oral evaluation - new or established patient.

D0180 Comprehensive periodontal evaluation - new or established patient.

COMPREHENSIVE EVALUATION: D0150, D0180

- Coverage is limited to 1 of each of these procedures per 1 provider.
- In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0120, D0145, also contribute(s) to this limitation.
- If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0150, D0180, also contribute(s) to this limitation.
- Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

COMPLETE SERIES OR PANORAMIC FILM

D0210 Intraoral - complete series (including bitewings).

D0330 Panoramic film.

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330

- Coverage is limited to 1 of any of these procedures per 3 year(s).

OTHER XRAYs

D0220 Intraoral - periapical first film.

D0230 Intraoral - periapical each additional film.

D0240 Intraoral - occlusal film.

D0250 Extraoral - first film.

D0260 Extraoral - each additional film.

PERIAPICAL FILMS: D0220, D0230

- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

BITEWING FILMS

D0270 Bitewing - single film.

D0272 Bitewings - two films.

D0273 Bitewings - three films.

D0274 Bitewings - four films.

D0277 Vertical bitewings - 7 to 8 films.

BITEWING FILMS: D0270, D0272, D0273, D0274

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0277, also contribute(s) to this limitation.
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWING FILM: D0277

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

PROPHYLAXIS (CLEANING) AND FLUORIDE

D1110 Prophylaxis - adult.

D1120 Prophylaxis - child.

D1203 Topical application of fluoride (prophylaxis not included) - child.

D1204 Topical application of fluoride (prophylaxis not included) - adult.

PREVENTIVE PROCEDURES

D1206 Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.

FLUORIDE: D1203, D1204, D1206

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D4910, also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

SEALANT

D1351 Sealant - per tooth.

SEALANT: D1351

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- Benefits are considered for persons age 16 and under.
- Benefits are considered on permanent molars only.
- Coverage is allowed on the occlusal surface only.

SPACE MAINTAINERS

D1510 Space maintainer - fixed - unilateral.

D1515 Space maintainer - fixed - bilateral.

D1520 Space maintainer - removable - unilateral.

D1525 Space maintainer - removable - bilateral.

D1550 Re-cementation of space maintainer.

D1555 Removal of fixed space maintainer.

SPACE MAINTAINER: D1510, D1515, D1520, D1525

- Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.

APPLIANCE THERAPY

D8210 Removable appliance therapy.

D8220 Fixed appliance therapy.

APPLIANCE THERAPY: D8210, D8220

- Coverage is limited to the correction of thumb-sucking.

COVERED EXPENSES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary
PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge
BENEFIT PERIOD - Calendar Year

For Additional Limitations - See Limitations

LIMITED ORAL EVALUATION

D0140 Limited oral evaluation - problem focused.

D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).

LIMITED ORAL EVALUATION: D0140, D0170

- Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

SEALANT

D1351 Sealant - per tooth.

SEALANT: D1351

- Coverage is limited to 1 of any of these procedures per 1 lifetime.
- Benefits are considered for persons age 13 and under.
- Benefits are considered on permanent molars only.
- Coverage is allowed on the occlusal surface only.

AMALGAM RESTORATIONS (FILLINGS)

D2140 Amalgam - one surface, primary or permanent.

D2150 Amalgam - two surfaces, primary or permanent.

D2160 Amalgam - three surfaces, primary or permanent.

D2161 Amalgam - four or more surfaces, primary or permanent.

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D9911, also contribute(s) to this limitation.
- Three or more surface procedures will be considered as the corresponding two surface procedure.

RESIN RESTORATIONS (FILLINGS)

D2330 Resin-based composite - one surface, anterior.

D2331 Resin-based composite - two surfaces, anterior.

D2332 Resin-based composite - three surfaces, anterior.

D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior).

D2391 Resin-based composite - one surface, posterior.

D2392 Resin-based composite - two surfaces, posterior.

D2393 Resin-based composite - three surfaces, posterior.

D2394 Resin-based composite - four or more surfaces, posterior.

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Three or more surface procedures will be considered as the corresponding two surface procedure.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

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Rate Information

Rate data does NOT apply to filing.

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Supporting Document Schedules

Satisfied -Name: Flesch Certification **Review Status:** Approved-Closed 03/16/2009
Comments:
Attachments:
ar-readability-sic.pdf
ar-regulation 19-certification-sic.pdf

Bypassed -Name: Application **Review Status:** Approved-Closed 03/16/2009
Bypass Reason: n/a
Comments:

STATE OF ARKANSAS
CERTIFICATE OF READABILITY

INSURER:

This is to certify that the attached form(s) has achieved a Flesch Reading Ease Score of:

FORM NO:

FLESCH SCORE:

FORM NAME:

<u>FORM NO:</u>	<u>FLESCH SCORE:</u>	<u>FORM NAME:</u>
_____	_____	_____
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complies with the requirements of Ark. Stat. Ann. Sections 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

SIGNATURE: _____

TYPED NAME:

TITLE:

DATE: _____

STATE OF ARKANSAS

REGULATION 19

INSURER:

This is to certify that the attached form(s) are in compliance with Rule and Regulation 19:

Form Number:

Form Name:

SIGNATURE:

TYPED NAME: _____

TITLE: _____

DATE: _____