

SERFF Tracking Number:	SNLF-125759955	State:	Arkansas
Filing Company:	Sun Life Assurance Company of Canada	State Tracking Number:	39833
Company Tracking Number:	SLOC DENTAL 2008		
TOI:	H10G Group Health - Dental	Sub-TOI:	H10G.000 Health - Dental
Product Name:	Group Dental		
Project Name/Number:	SLOC Dental 2008/SLOC Dental 2008		

Filing at a Glance

Company: Sun Life Assurance Company of Canada

Product Name: Group Dental	SERFF Tr Num: SNLF-125759955	State: ArkansasLH
TOI: H10G Group Health - Dental	SERFF Status: Closed	State Tr Num: 39833
Sub-TOI: H10G.000 Health - Dental	Co Tr Num: SLOC DENTAL 2008	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Authors: Lori Chilcote, Ellen Thibodeau	Disposition Date: 08/16/2008
	Date Submitted: 08/04/2008	Disposition Status: Approved-Closed
Implementation Date Requested:		Implementation Date:

State Filing Description:

General Information

Project Name: SLOC Dental 2008	Status of Filing in Domicile: Not Filed
Project Number: SLOC Dental 2008	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Employer, Association, Trust
Filing Status Changed: 08/16/2008	Deemer Date:
State Status Changed: 08/16/2008	
Corresponding Filing Tracking Number:	
Filing Description:	
Dear Commissioner Bowman:	

We are submitting the forms identified on the attached list for review and approval for use by Sun Life Assurance Company of Canada. These forms are new and not intended to replace any other forms currently in use.

<i>SERFF Tracking Number:</i>	<i>SNLF-125759955</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Sun Life Assurance Company of Canada</i>	<i>State Tracking Number:</i>	<i>39833</i>
<i>Company Tracking Number:</i>	<i>SLOC DENTAL 2008</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>Group Dental</i>		
<i>Project Name/Number:</i>	<i>SLOC Dental 2008/SLOC Dental 2008</i>		

Any items intended to be variable are bracketed. An Explanation of Variable parameters is enclosed, along with other all other filing requirements. As a point of information, variable data may vary from case to case. For example, the nature and structure of a group may require that certain terms be changed to fit the specific group. Amounts may vary or provisions may be modified to fit a specific policyholder's request. There may be other variations that may be changed as a result of negotiations between the policyholder and the Company. Please be assured that variable data will never exclude or limit provisions required by the jurisdiction in which the group policy is issued. With respect to mandated requirements, benefits greater than the mandates may be provided, where permitted.

Attached to this filing are any applicable state required fees, transmittal forms, and certifications.

If you have any questions or comments regarding this submission, please contact me at:
(860) 737-1083, or email me at Ellen.thibodeau@sunlife.com.

Company and Contact

Filing Contact Information

Ellen Thibodeau, Compliance Consultant	Ellen.Thibodeau@sunlife.com
175 Addison Road	(860) 737-1083 [Phone]
Windsor, CT 06095-0725	(860) 737-6598[FAX]

Filing Company Information

Sun Life Assurance Company of Canada	CoCode: 80802	State of Domicile: Michigan
175 Addison Road	Group Code: 549	Company Type:
Windsor, CT 06095	Group Name:	State ID Number:
(860) 737-1000 ext. [Phone]	FEIN Number: 38-1082080	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$20.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

SERFF Tracking Number: SNLF-125759955 *State:* Arkansas
Filing Company: Sun Life Assurance Company of Canada *State Tracking Number:* 39833
Company Tracking Number: SLOC DENTAL 2008
TOI: H10G Group Health - Dental *Sub-TOI:* H10G.000 Health - Dental
Product Name: Group Dental
Project Name/Number: SLOC Dental 2008/SLOC Dental 2008

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Sun Life Assurance Company of Canada	\$20.00	08/04/2008	21760011

SERFF Tracking Number: SNLF-125759955 State: Arkansas
Filing Company: Sun Life Assurance Company of Canada State Tracking Number: 39833
Company Tracking Number: SLOC DENTAL 2008
TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
Product Name: Group Dental
Project Name/Number: SLOC Dental 2008/SLOC Dental 2008

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/16/2008	08/16/2008

SERFF Tracking Number: SNLF-125759955 *State:* Arkansas
Filing Company: Sun Life Assurance Company of Canada *State Tracking Number:* 39833
Company Tracking Number: SLOC DENTAL 2008
TOI: H10G Group Health - Dental *Sub-TOI:* H10G.000 Health - Dental
Product Name: Group Dental
Project Name/Number: SLOC Dental 2008/SLOC Dental 2008

Disposition

Disposition Date: 08/16/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: SNLF-125759955 State: Arkansas
 Filing Company: Sun Life Assurance Company of Canada State Tracking Number: 39833
 Company Tracking Number: SLOC DENTAL 2008
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
 Product Name: Group Dental
 Project Name/Number: SLOC Dental 2008/SLOC Dental 2008

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Cover letter & NAIC Transmittal	Approved-Closed	Yes
Supporting Document	List of previously approved forms (SLHIC)	Approved-Closed	Yes
Supporting Document	Dental QA 06-08 AG	Approved-Closed	Yes
Supporting Document	Explanation of Variables	Approved-Closed	Yes
Form	Group Application & Policy Form	Approved-Closed	Yes
Form	Group Certificate Forms	Approved-Closed	Yes

SERFF Tracking Number: SNLF-125759955 State: Arkansas
 Filing Company: Sun Life Assurance Company of Canada State Tracking Number: 39833
 Company Tracking Number: SLOC DENTAL 2008
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
 Product Name: Group Dental
 Project Name/Number: SLOC Dental 2008/SLOC Dental 2008

Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	GA-A (94) et al	Other	Group Application & Policy Form	Initial		52	GA-A (94) et al.pdf
Approved-Closed	GC-A-1 et al.	Certificate	Group Certificate Forms	Initial		50	GC-A-1 et al.pdf

APPLICATION FOR GROUP INSURANCE

Application is hereby made to SUN LIFE ASSURANCE COMPANY OF CANADA
of Wellesley Hills, Massachusetts

[By ABC COMPANY

Of 123 MAIN STREET, ANYTOWN, AR 00000

For Group Insurance Policy Number 000-0000]

The Policyholder hereby approves and accepts the terms of said policy which will be effective as of the effective date specified therein.

It is agreed that this application supersedes any prior application for such policy.

[State law, in some states, requires the following statement: A person commits a fraudulent insurance act, which is a crime, if he or she knowingly and with intent to defraud any insurance company or other person, either: (1) Files an application for accident and health insurance or statement of claim containing any materially false information; or (2) Conceals for the purpose of misleading, information about any fact that is material to a claim. VIOLATIONS ARE SUBJECT TO CRIMINAL PROSECUTION AND MAY ALSO RESULT IN SUBSTANTIAL CIVIL PENALTIES.]

Signed at _____

On _____

ABC COMPANY

By _____

(Policyholder)

Attach one copy to the Policy and return one copy to Sun Life Assurance Company of Canada

Sun Life Assurance Company of Canada

One Sun Life Executive Park
Wellesley Hills, MA 02481

POLICYHOLDER: ABC COMPANY

POLICY NO: 000-0000

POLICY EFFECTIVE DATE: NOVEMBER 1, 2008

POLICY ANNIVERSARY: NOVEMBER 1 OF EACH YEAR BEGINNING IN 2009

STATE OF ISSUE: ARKANSAS

PREMIUM DUE DATE: THE FIRST DAY OF EACH MONTH AFTER THE EFFECTIVE DATE

We agree to pay the benefits of this policy in accordance with its provisions with respect to [Employees] insured hereunder.

This policy is issued to the Policyholder shown above in consideration of the Policyholder's application and payment of premiums. Premiums are payable in advance at our U.S. Headquarters or at another location designated by us. The first premium is due on the effective date. Subsequent premiums are due on the premium due date.

This policy is delivered in and governed by the laws of the state of issue, as shown above.

This policy is signed for Sun Life Assurance Company of Canada at its U.S. Headquarters, One Sun Life Executive Park, Wellesley Hills, MA 02481.

[*Donald A. Stewart.*]

[Chief Executive Officer]

[*Jan Nican*]

[Secretary]

Table of Contents

	Page
Agreement to Insure	1
[[Subsidiary and Affiliated Employers	2]]
Incorporation Provisions	3
Termination Provisions	4
Premiums	5
General Provisions	6

[[SUBSIDIARY AND AFFILIATED EMPLOYERS

The [Policyholder] may act for or on behalf of all Subsidiary or Affiliated Employers named on the [application], in all matters of the policy.

- A. The following will be binding on all employers:
 - 1. All agreements between Sun Life Assurance Company of Canada and the [Policyholder].
 - 2. All notices from Sun Life Assurance Company of Canada to the [Policyholder]; and
 - 3. All notices from the [Policyholder] to Sun Life Assurance Company of Canada.
- B. An employer may be included under this policy as a Subsidiary or Affiliated Employer if:
 - 1. The [Policyholder] and Sun Life Assurance Company of Canada so agree; and
 - 2. The inclusion is allowed by the law of the jurisdiction in which the policy is delivered.
- C. An employee of a Subsidiary or Affiliated Employer will be deemed to be an employee of the [Policyholder] for insurance purposes.
- D. The coverage of an employee of a Subsidiary or Affiliated Employer will terminate on the first to occur of:
 - 1. The date premium is due but not paid; or
 - 2. The date on which the employer and the Policyholder are no longer associated in a way acceptable to Sun Life Assurance Company of Canada for insurance purposes.]]

INCORPORATION PROVISIONS

Certificate(s)

[The Certificate(s) and any Certificate Amendment forms that are attached (held by Sun Life Assurance Company of Canada at its U.S. Headquarters in Wellesley Hills, Massachusetts) to this policy are hereby incorporated in, and made part of this policy and provide the following Group Insurance benefits:

Dental]

The terms found in the Certificate(s) and/or any Certificate Amendment will control:

1. The benefit plan provisions;
2. The eligibility and effective date provisions;
3. The termination provisions;
4. Exclusions; and
5. Other policy provisions pertaining to state insurance requirements.

Insurance Schedule

The Insurance Schedule shown in the Certificate(s) will control the following provisions that apply to the [Employees] of the [Policyholder]:

1. Benefit amounts and maximum limits;
2. Applicable coinsurance percentages;
3. Eligibility and effective date provisions; and
4. Other schedule amounts and limits.

TERMINATION PROVISIONS

Termination **[[of Employer's Participation]]** **[[of the Policy]]**

[[An Employer's participation in the Trust and under]] the policy will end on the earliest of:

1. The last day of a [31] day period in which the [Employer] fails to give us [[or the Policyholder]] the payment that is required [[as a condition for the Employer's continued participation]];
2. The first premium due date after the [Employer] notifies us [[or the Policyholder]] in writing that [[such Employer does not wish to continue participation]] [[the policy should be terminated]];
3. The date that we specify in advance written notice to the [Employer]. We may give this notice at any time, but not less than 30 days in advance of such date. Occasions on which we may give this notice include but are not limited to:
 - a) with respect [[to Employers with]] Contributory Insurance, at any time when the [Employer] has less than 75% of all Eligible Employees insured under this policy[[, unless otherwise stated in the [Policyholder's] Plan of Insurance]].

The term Eligible Employees in this item 3-a does not include any [Employee] who is not insured solely because he or she could not submit Evidence of Insurability;
 - b) with respect to [[Employers with]] Non-Contributory Insurance, at any time when the Employer does not report all Employees who are eligible for insurance under the policy;
 - c) at any time when the [Employer] fails:
 - i) to furnish promptly any information that we may reasonably require; or
 - ii) to perform any other obligations pertaining to this policy; or
 - d) at any time when the [Employer] ceases to qualify for insurance coverage under the policy in accordance with our then current standard underwriting rules and practices.
4. Any date the [Employer] does not have at least [2] Employees insured under this policy; or
5. Any date the [Employer] is not actively engaged in the business that we agreed to insure.

[[Our Right to Terminate the Policy

We have the right to terminate the policy on the first day of any month after we give the Policyholder at least 60 days notice of our intent to terminate.]]

Once we have terminated the policy, the insurance that it provides will end automatically. See Extended Benefit Provisions for times when benefits may be extended after insurance ends.

PREMIUMS

Computing [Employer] and [Employee] Premiums

Premiums for any insurance becoming effective for all of the [Policyholder's] [Employees] will be due from the effective date. Thereafter, all premiums will be due on the premium due dates.

Premium charges for insurance terminated as to all of the [Policyholder's] [Employees] will cease as of:

1. The termination date; or
2. The end of the grace period if insurance is in force for the grace period.

Charges for any insurance becoming effective or terminating for an individual [Employee], other than as stated above, will begin or end as of the first day of the month coinciding with or next following the effective date or termination date, as the case may be.

Instead of determining premiums as stated above, premiums may be determined by any method satisfactory to the Policyholder and us.

Changes in Computing the Premium

Instead of computing the premium on the rate basis shown below, we may use any method that we and the Policyholder agree to. We have the right to change the Initial Monthly Premium Rates below [[with respect to any or all employers]] as of any premium due date that occurs at least [6] months after the date of issue without consent of the Policyholder, any [[Employer,]] Employee, or any other person. We will provide written notification of any increases in the premium rate basis to the [Employer] at least 31 days prior to the effective date of the increase.

INITIAL MONTHLY PREMIUM RATES

The Initial Monthly Premium Rates are as shown below:

[Dental Benefits	<u>\$00.00</u>	Employee Only
	<u>\$00.00</u>	Employee and Spouse
	<u>\$00.00</u>	Employee, Spouse and Dependent Children]

GENERAL PROVISIONS

[31] Day Grace Period To Pay Premium Due

The Policyholder [[and each Employer]] has a grace period of [31] days after the Premium Due Date in which to pay the premium for the insurance provided under this policy. If the Policyholder [[or the Employer]] does not pay the premium before the end of the grace period, this policy will automatically cease at the end of the grace period [[for any or all Employers with respect to whom premiums have not been paid]]. If the Policyholder [[or the Employer]] gives us advance written notice that the policy will cease on an earlier date, then the policy will cease on that date; but no such termination will take effect during any period for which a premium has been paid to us.

The Policyholder [[or the Employer]] is liable to us for the premium that is due during that part of the grace period that the insurance remains in force or the entire grace period if written notice is not received prior to the end of the grace period.

Information That We May Need

The Policyholder [[and the Employer]] must give us on our forms any information that we may need to compute premiums, provide insurance coverage and keep records. Such information as to any individual will be binding upon that individual, and we will rely on it as such. At all reasonable times while the policy is in force and until we resolve all rights and duties under it, we can inspect any of the Policyholder's [[or the Employer's]] records that would, in our judgment, have any effect on the insurance provided under the policy.

Certificates of Insurance

We will provide the [Policyholder] with a certificate of insurance to be given to each [Employee]. The certificate will explain the important features of the policy and to whom we will pay benefits.

SUN LIFE ASSURANCE COMPANY OF CANADA issues this rider to be attached to and form part of Group Policy No. 000-0000-00 issued

To

ABC COMPANY

The policy is changed as follows:

[1. The name of the Policyholder as set forth on the Policy cover page is changed to read:

Policyholder: <new name>

2. Notice is hereby acknowledged by Sun Life Assurance Company of Canada that all right, title and interest of <old name> in and to the group policy has been assigned to <new name>.

3. It is hereby agreed that said <new name>> will assume the rights and obligations of said <old name> under the policy and that the policy will continue in full force and effect.]

Nothing contained in this rider will be held to affect any of the terms of the policy other than as stated herein.

This Rider will be effective on June 1, 2008.

SUN LIFE ASSURANCE COMPANY OF CANADA

[*Donald A. Stewart.*]

[Chief Executive Officer]

Rider No. _____

GP-AR

SUN LIFE ASSURANCE COMPANY OF CANADA certifies that it has issued and delivered a Group Insurance Policy to the Policyholder shown below.

[POLICYHOLDER: ABC COMPANY, INC.

EFFECTIVE DATE: APRIL 1, 2008

ACCOUNT NUMBER: 000-0000-00

GROUP POLICY NO: 000-0000

STATE OF ISSUE: ARKANSAS

[[This Plan contains a provision entitled "LIMITATION ON LATE ENTRANTS." If you submit an enrollment card more than 31 days after you become an Eligible Employee or if you request reinstatement of insurance that was terminated while you remained eligible for insurance under the policy, benefits for some services may not be available. For a complete description of the Late Entrant provision, please refer to the section entitled "LIMITATION ON LATE ENTRANTS" in the "Employee Insurance" and "Dependent Coverage" parts of the certificate.]]

PRE-DETERMINATION OF BENEFITS

This Plan contains a provision entitled "PRE-DETERMINATION OF BENEFITS." For a complete description of the Pre-Determination Provision, please refer to the section entitled "PRE-DETERMINATION OF BENEFITS" in the "Determination of Benefits" part of the certificate.

This Certificate cancels and replaces any prior Dental Expense Benefits Certificate issued to you.

This Group Certificate contains the terms of the Group Policy that affect your insurance. This Group Certificate is part of the Group Policy.

This Group Certificate is governed by the laws of the State of Issue shown above, which is the state of issue of the group policy.

[*Donald A. Stewart.*]

[Chief Executive Officer]

COMPLAINT NOTICE

Should any dispute arise regarding your premium or a claim that you have filed, call or write the following department of this company:

Sun Life Assurance Company of Canada
[Group Policyholder Service
101 Munson Street
Greenfield, MA 01301
Toll-free: 1-800-451-2513]

If your problem is not resolved, you may also call or write to the Arkansas Insurance Department at the following address:

Arkansas Insurance Department
Consumer Service Division
[1200 West Third Street
Little Rock, Arkansas 72201-1904
Telephone: (501) 371-2640]

This notice of complaint procedure is for information only and does not become a part or condition of this policy.

COORDINATION OF BENEFITS INCLUDED - SEE PAGE GC-A-9

Disclosure of Information Group Dental Plan

[The following document provides you with information regarding your Group Dental Benefits. This document is intended to clarify and to provide additional information about your plan. Your Group Certificate provides detailed provisions of coverage including any limitations or restrictions that apply. **You should read your certificate carefully.**

Dental PPO Network

Our Dental PPO is a group dental insurance program provided by us that utilizes a nationwide network of dentists. DenteMax is the dental network administrator used by us and is responsible for the development and management of our PPO provider networks. DenteMax strives to provide the most comprehensive network of dentists possible in all areas across the country. In order to ensure that the highest standards are met, DenteMax utilizes a National Committee for Quality Assurance accredited organization to conduct credentials verification. All providers have the right to participate in the DenteMax Dental PPO network provided all enrollment criteria is met and they are willing to meet the terms and conditions for participation. Key features of this plan include:

- You may receive services from a provider of your choice
- You may receive a higher level of benefits for dental services when choosing a PPO provider

Dental Emergency Treatment

In the event of a dental emergency, a covered person can seek treatment from a provider of his/her choice. Treatment for a dental emergency is paid the same as treatment for a non-emergency.

Provider Directories

You may obtain provider directories by contacting our Group Policyholder Services department (GPS) at 800-451-2513 or you may view the list of participating providers on our web site at <http://ebg.sunlife.com>. It is possible that a provider may have left or joined the network since the printing of the directory. In order to verify that a provider is a participant, you may contact the provider directly.]]

Financial Arrangements

Reimbursements to dental service providers are based on various factors. [[When services are provided in the PPO network, charges are on a discounted fee-for-service basis.

The provider is not given an incentive or bonus that encourages withholding service or influences referrals to specialists.]] If you desire additional information about how providers [[in the network]] are compensated, please contact us at the address or telephone number shown below.

[[Provider Contracts

PPO provider contracts do not include "gag" clauses. Contracts do not prohibit the provider from discussing available treatment options and services or from disclosing the compensation methodology to covered persons.]]

Covered Expenses

Pre-Determination of Benefits

Pre-Determination of Benefits is recommended for some services. These are described in the *Determination of Benefits* part of the certificate. We will notify you and the Dentist of the benefits payable based upon the dental treatment plan that was submitted. In determining the amount of benefits payable, consideration will be given to alternate dental treatment that will accomplish a professionally satisfactory result. If you and the Dentist agree to a more costly method of treatment, the excess amount will not be paid by us.

Pre-Determination of Benefits is not a guarantee of benefits under your dental plan. You or your dependent must meet the plan's eligibility requirements and services must be a covered expense for benefits to be payable. Please be sure to read your certificate carefully to ensure coverage is provided under your plan.]

[Retrospective Review

Certain claims are subject to retrospective review to determine whether the supplies or services provided are essential as required by your plan. Other than expenses for which coverage is required by state law, expenses for treatment or supplies that are not essential are not covered by your plan.

Description of Benefits

The *Insurance Schedule* and *Dental Expense Benefits: Covered Expenses* parts of your Group Certificate contain information regarding benefits including benefit maximums and limitations. The *Insurance Schedule* part outlines the benefit levels for treatment [[both in and out of network]] including information about your responsibility for payment related to coinsurance, co-payments, deductibles and annual limits. If services are not covered by the plan, you are responsible for payment.

The *Dental Expense Benefits: Exclusions* part of your Group Certificate contains information about charges for which no benefits are paid. Benefits are payable for essential treatment, subject to all of the provisions of your Group Certificate.

Confidentiality of Patient Information

Dental records and other patient information will be released only upon written authorization from the insured. Such information may only be used to determine eligibility and benefits payable under the plan. All our employees take appropriate measures to safeguard the security and confidentiality of patient information.

[[Rights and Responsibilities

We are committed to treating all our enrollees in a manner that respects their rights under this contract. We expect the providers of care to treat our enrollees as they would any other patient in terms of care provided, accommodations, and timeliness of access to care.

Our Dental PPO does not solicit enrollee satisfaction information.]]

Grievance Process:

If you disagree with a claim decision made by us, within 180 calendar days of receipt of such claim decision, you, your dentist, or your representative may call or write to us at the address listed below to initiate an appeal.

Manager, Group Dental Benefits

P.O. Box 1477

Greenfield, MA 01302

Toll-free telephone number: 1-800-451-2513

Hours: MON-FRI 8:00 A.M. to 6:00 P.M. ET]

Table of Contents

	Page
[PART 1: INSURANCE SCHEDULE.....	3
PART 2: DEFINITIONS.....	8
PART 3: DENTAL EXPENSE BENEFITS: EMPLOYEE INSURANCE	13
[[PART 3A: DENTAL EXPENSE BENEFITS: DEPENDENT COVERAGE	15
PART 4: DENTAL EXPENSE BENEFITS: DETERMINATION OF BENEFITS.....	17
[PART 5: DENTAL EXPENSE BENEFITS: COVERED DENTAL EXPENSES.....	22
[PART 5: DENTAL EXPENSE BENEFITS: COVERED DENTAL EXPENSES.....	27
PART 6: DENTAL EXPENSE BENEFITS: EXCLUSIONS.....	40
PART 7: DENTAL EXPENSE BENEFITS: COORDINATION OF BENEFITS.....	43
PART 8: TERMINATION PROVISIONS	47
PART 8A: UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS ACT OF 1994.....	48
PART 9: GENERAL PROVISIONS	49
PART 10: GENERAL DENTAL PROVISIONS.....	50]

PART 1: INSURANCE SCHEDULE

DENTAL EXPENSE BENEFITS EMPLOYEE [[AND DEPENDENTS]]

Employee

EACH FULL-TIME NON-UNION EMPLOYEE

Date of Eligibility (Waiting Period):

90 DAYS

[SCHEDULE OF DENTAL BENEFITS

<u>Covered Expense</u>	<u>Per Person Deductible</u>	<u>Percentage of Covered Expenses Payable</u>	<u>Per Person Maximum Benefit</u>
Type I	\$ <u>150.00</u> [[per Lifetime]] [[per Calendar Year]]	<u>60%</u>	Per Calendar Year: \$ <u>500.00</u> for Type I, II and III [[and vision care]] expenses combined.
[[Type II	\$ <u>150.00</u> [[per Lifetime]] [[per Calendar Year]]	<u>50%]]</u>	[[Per Calendar Year: \$ <u>250.00</u> for Type II]]
[[Type III	\$ <u>150.00</u> [[per Lifetime]] [[per Calendar Year]]	<u>30%]]</u>	[[Per Calendar Year: \$ <u>250.00</u> for Type III]]
[[Type IV	\$ <u>150.00</u> [[per Lifetime]] [[per Calendar Year]]	<u>30%]]</u>	Type IV limited to [[<u>\$250.00</u> per Calendar Year and]]: \$ <u>500.00</u> per Lifetime]].

*After applicable Deductible.

[[Only one deductible applies per [[Calendar Year]] [[Lifetime]] if Type I, II, III, and IV Dental Expenses [[and vision care expenses]] are incurred.]]

[[The Maximum Family Deductible is \$450.00.]]

[[The Maximum Family Benefit is \$1,500.00 for Type I, II and III Expenses combined.]]]

[[SCHEDULE OF DENTAL BENEFITS

Covered Expense	Per Person Deductible	Percentage of Covered Expenses Payable*		Per Person Maximum Benefit
		PPO Expenses ¹	Non-PPO Expenses ^{[[2]]}	
Type I	\$150.00 [[per Lifetime]] [[per Calendar Year]]	100%	100% ^{[[1]] [[2]][[3]]}	Per Calendar Year: \$500.00 for Type I, II and III [[and vision care]] expenses combined. [[Per Calendar Year: \$250.00 for Type II]]
[[Type II	\$150.00 [[per Lifetime]] [[per Calendar Year]]	90%	80% ^{[[1]] [[2]][[3]]}	
[[Type III	\$150.00 [[per Lifetime]] [[per Calendar Year]]	60%	50% ^{[[1]] [[2]][[3]]}	[[Per Calendar Year: \$250.00 for Type III]]
[[Type IV	\$150.00 [[per Lifetime]] [[per Calendar Year]]	60%	50% ^{[[1]][[2]] [[3]]}	Type IV limited to [[\$250.00 per Calendar Year and]] \$500.00 Per Lifetime

*After applicable Deductible.

[[Only one deductible applies per [[Calendar Year]] [[Lifetime]] if Type I, II, III, and IV dental expenses [[and vision care expenses]] are incurred.]]

[[The Maximum Family Deductible is \$450.00.]]

[[The Maximum Family Benefit is \$1,500.00 for Type I, II and III expenses combined.]]

¹ Benefits based on Schedule Charge.

² Benefits based on Usual and Customary Charges.

³ Benefits based on Allowable Charge

[[If a Covered Person uses the services of a PPO Provider, that provider is entitled to collect from you the difference between the amount of benefits payable by us and the Schedule Charge. If a Covered Person uses the services of a Non-PPO Provider, that provider is entitled to collect from you the difference between the amount of benefits payable by us and the provider's [billed] charge.]]

[[Covered Expenses are determined by the Schedule Charge whether or not services are rendered by a PPO Provider.]]

[[With respect to services rendered by a PPO Provider, Covered Expenses are determined by the Schedule Charge. With respect to services rendered by a Non-PPO Provider, Covered Expenses are determined by the Allowable Charge.]]]]

[[SCHEDULE OF DENTAL BENEFITS

For COVERED DENTAL EXPENSES incurred during the first 12 months a Covered Person is insured under the policy:

<u>Covered Expense</u>	<u>Per Person Deductible</u>	<u>Percentage of Covered Expenses Payable*</u>		<u>Per Person Maximum Benefit</u>
		<u>PPO Expenses¹</u>	<u>Non-PPO Expenses^{[[2]]}</u>	
Type I	\$100.00 [[per Lifetime]] [[per Calendar Year]]	80%	60% ^{[[1]][[2]][[3]]}	\$500.00 per Calendar Year for Type I, II and III [[and vision care]] expenses combined [[\$250.00 per Calendar Year for Type II]]
Type II	\$100.00 [[per Lifetime]] [[per Calendar Year]]	60%	30% ^{[[1]][[2]][[3]]}	[[\$250.00 per Calendar Year for Type II]]
[[Type III	\$100.00 [[per Lifetime]] [[per Calendar Year]]	25%	Not Available	[[\$250.00 per Calendar Year for Type III]]
[[Type IV	\$100.00 [[per Lifetime]] [[per Calendar Year]]	60%	50% ^{[[1]][[2]][[3]]}	\$500.00 per Lifetime [[and \$250.00 per Calendar Year for Type IV]]]

For COVERED DENTAL EXPENSES incurred after a Covered Person has been insured under the policy for 12 consecutive months:

<u>Covered Expense</u>	<u>Per Person Deductible</u>	<u>Percentage of Covered Expenses Payable*</u>		<u>Per Person Maximum Benefit</u>
		<u>PPO Expenses¹</u>	<u>Non-PPO Expenses^{[[2]]}</u>	
Type I	\$100.00 [[per Lifetime]] [[per Calendar Year]]	80%	70% ^{[[1]][[2]][[3]]}	\$500.00 per Calendar Year for Type I, II and III [[and vision care]] expenses combined [[\$250.00 per Calendar Year for Type II]]
Type II	\$100.00 [[per Lifetime]] [[per Calendar Year]]	60%	40% ^{[[1]][[2]][[3]]}	[[\$250.00 per Calendar Year for Type II]]
[[Type III	\$100.00 [[per Lifetime]] [[per Calendar Year]]	40%	20% ^{[[1]][[2]][[3]]}	[[\$250.00 per Calendar Year for Type III]]
[[Type IV	\$100.00 [[per Lifetime]] [[per Calendar Year]]	60%	50% ^{[[1]][[2]][[3]]}	\$500.00 [[per Lifetime]] [[and \$250.00 per Calendar Year for Type IV]]]]

[[For COVERED DENTAL EXPENSES incurred after a Covered Person has been insured under the policy for 24 consecutive months:

Covered Expense	Per Person Deductible	Percentage of Covered Expenses Payable*		Per Person Maximum Benefit
		<u>PPO Expenses</u> ¹	<u>Non-PPO Expenses</u> ^{[[2]]}	
Type I	<u>\$100.00</u> [[per Lifetime]] [[per Calendar Year]]	<u>80%</u>	<u>80%</u> ^{[[1]][[2]] [[3]]}	\$500.00 per Calendar Year for Type I, II and III [[and vision care]] expenses combined [[<u>\$250.00</u> per Calendar Year for Type II]]
Type II	<u>\$100.00</u> [[Per Lifetime]] [[per Calendar Year]]	<u>60%</u>	<u>50%</u> ^{[[1]][[2]] [[3]]}	[[<u>\$250.00</u> per Calendar Year for Type II]]]
[[Type III	<u>\$100.00</u> [[per Lifetime]] [[per Calendar Year]]	<u>40%</u>	<u>30%</u> ^{[[1]][[2]] [[3]]}	[[<u>\$250.00</u> per Calendar Year for Type II]]]]
[[Type IV	<u>\$100.00</u> [[per Lifetime]] [[per Calendar Year]]	<u>60%</u>	<u>50%</u> ^{[[1]][[2]] [[3]]}	\$500.00 [[per Lifetime [[and <u>\$250.00</u> per Calendar Year]]]]]]

*After applicable Deductible.

[[Only one deductible applies per [[Calendar Year]] [[Lifetime]] if Type I, II, III and IV [[and vision care expenses]] expenses are incurred.]]

[[The Maximum Family Deductible is \$150.00.]]

[[The Per Person Maximum Benefit is for Type I, II, III and IV [[and vision care expenses]] combined.]]

[[The Maximum Family Benefit is \$3000.00 for Type I, II, III and IV [[and vision care expenses]] combined.]]

¹ Benefits based on Schedule Charge.

² Benefits based on Usual and Customary Charges.

³ Benefits based on Allowable Charge.

[[If a Covered Person uses the services of a PPO Provider, that provider is entitled to collect from you the difference between the amount of benefits payable by us and the Schedule Charge. If a Covered Person uses the services of a Non-PPO Provider, that provider is entitled to collect from you the difference between the amount of benefits payable by us and the provider's [billed] Charge.]]

[[Covered Expenses are determined by the Schedule Charge whether or not services are rendered by a PPO Provider.]]

[[With respect to services rendered by a PPO Provider, Covered Expenses are determined by the Schedule Charge. With respect to services rendered by a Non-PPO Provider, Covered Expenses are determined by the Allowable Charge.]]]]

[[SCHEDULE OF DENTAL BENEFITS PPO EXPENSES¹

<u>Covered Expense</u>	<u>Per Person Deductible</u>	<u>Percentage of Covered Expenses Payable*</u>	<u>Per Person Maximum Benefit</u>
Type I	\$ <u>150.00</u>	<u>60%</u>	Per Calendar Year: <u>\$500.00</u> for Type I, II and III expenses combined.
[[Type II	\$ <u>150.00</u>	<u>50%]]</u>	
[[Type III	\$ <u>150.00</u>	<u>30%]]</u>	
[[Type IV	\$ <u>150.00</u>	<u>30%</u>	Per Lifetime: <u>\$500.00</u> for Type IV]].

NON-PPO EXPENSES²

<u>Covered Expense</u>	<u>Per Person Deductible</u>	<u>Percentage of Covered Expenses Payable*</u>	<u>Per Person Maximum Benefit</u>
Type I	\$ <u>300.00</u>	<u>40%</u> ^{[[1]]} [[2]] ^{[[3]]}	Per Calendar Year: <u>\$250.00</u> for Type I, II and III expenses combined.
[[Type II	\$ <u>300.00</u>	<u>30%</u> ^{[[1]]} [[2]] ^{[[3]]}]]	
[[Type III	\$ <u>300.00</u>	<u>20%</u> ^{[[1]]} [[2]] ^{[[3]]}]]	
[[Type IV	\$ <u>300.00</u>	<u>20%</u> ^{[[1]]} [[2]] ^{[[3]]}]]	Per Lifetime: <u>\$250.00</u> for Type IV]]

*After applicable Deductible.

[[Only one deductible applies if Type I, II and III expenses are incurred.]]

[[With respect to PPO Expenses, only one deductible applies if Type I, II and III expenses are incurred.]]

[[With respect to Non-PPO Expenses, only one deductible applies if Type I, II and III expenses are incurred.]]

[[The Maximum Family Deductible for PPO Expenses is \$300.00 and for Non-PPO Expenses is \$900.00.]]

The Per Person Maximum Benefit for PPO and Non-PPO Expenses combined is:

a) \$500.00 per Calendar Year for Type I, II and III expenses combined; and

b) \$500.00 per Lifetime for Type IV expenses.

¹ Benefits based on Schedule Charge.

² Benefits based on Usual and Customary Charges.

³ Benefits based on Allowable Charge.

If a Covered Person uses the services of a PPO Provider, that provider is entitled to collect from you the difference between the amount of benefits payable by us and the Schedule Charge. If a Covered Person uses the services of a Non-PPO Provider, that provider is entitled to collect from you the difference between the amount of benefits payable by us and the provider's billed Charge.]

[[Covered Expenses are determined by the Schedule Charge whether or not services are rendered by a PPO Provider.]]

[[With respect to services rendered by a PPO Provider, Covered Expenses are determined by the Schedule Charge. With respect to services rendered by a Non-PPO Provider, Covered Expenses are determined by the Allowable Charge.]]]]

PART 2: DEFINITIONS

[Accidental Bodily Injury

A bodily injury resulting directly from an accident, and independently of all other causes.

Actively At Work

You are actively at work on any day if on that day you are:

1. Working at your Employer's usual place of business or at such place or places that the Employer's normal course of business may require;
2. Performing all of the duties of your job [[on a full-time basis]]; and
3. Not confined in any institution providing care or treatment of physical or mental infirmities.

[[Allowable Charge

A pre-determined fee for a given service.]]

[[Annual Election Period

A specified period each year, determined by the Employer, when you may elect to purchase Voluntary Dental Insurance.]]

[[Annual Plan Selection Period

A specified period each year, determined by the Employer, when you may elect to become covered under an alternate plan of Dental Expense Benefits made available by the Employer and provided by us.]]

Business Day

Any day of the week in which the provider of dental services normally conducts business of a non-emergency nature.

Calendar Year

The period beginning on January 1st and ending on December 31st of the same year.

[[Child

The term "Child":

1. Means a child who:
 - a) is unmarried;
 - b) is receiving more than 50% of support from you; or has been recognized as having the right to benefits under the plan under a qualified medical child support order or other similar court decree; and
 - c) is either:
 - i) under 19 years of age; or
 - ii) a Full-time Student and under 25 years of age; or
 - iii) a Handicapped Child as defined below; and
2. Is limited to:
 - a) your natural born child or other child related to you by blood;
 - b) your stepchild;
 - c) your foster child;
 - d) your legally adopted child or child placed with you pending adoption; and
 - [[e) the child of your Domestic Partner;]] and
3. Is subject to this restriction: No Child will be considered as a Dependent of more than one insured Employee.]]

Covered Person

You or your Dependent who is insured for DENTAL EXPENSE BENEFITS.

Customary Charge

A fee level selected by your Employer based on the amount standardly charged by most dental offices in the locality where the charge for a service is incurred. Locality means an area whose size is large enough, as determined by us, to give an accurate representation of standard charges for that type of service.]

[Dental Hygienist

Someone who meets both of the following requirements:

1. Is currently licensed to practice dental hygiene by the state in which he or she practices; and
2. Is acting under the supervision and direction of a Dentist.

Dental Prophylaxis

Preventive treatment which includes scaling and polishing, the complete removal of explorer-detectable calculus, soft deposits, plaque, stains and the smoothing of tooth surfaces coronal to the gingival attachment. For benefit purposes, periodontal maintenance shall be considered as an adult prophylaxis. A multiple appointment cleaning shall be considered as a single prophylaxis.

Dental Treatment Plan

The Dentist's report of recommended treatment on a form satisfactory to us which:

1. With respect to Type I, Type II and Type III COVERED DENTAL EXPENSES, itemizes the dental procedures and charges required for the necessary care of the mouth;
2. With respect to Type IV COVERED DENTAL EXPENSES, itemizes the orthodontic procedures and charges required for correction of malocclusion;
3. Lists the Usual Charges for each procedure; and
4. Is accompanied by supporting x-rays and any other appropriate diagnostic materials as required by us.

Dentist

Someone who meets both of the following requirements:

1. Is currently licensed to practice dentistry or denture technology by the state in which he or she practices; and
2. Is acting within the scope of his or her license.

[[Dependent

The term "Dependent":

1. Means:
 - a) your lawful spouse [[or Domestic Partner;]] or
 - b) your Child ; but
2. Does not include a person who:
 - a) is an Employee of your Employer unless you and your spouse [[or Domestic Partner]] are each Employees of your Employer and you have or acquire a Dependent Child. In that event, the Employee whose employment date with your Employer is the later of the two will be insured as a Dependent rather than an Employee, subject to the "Date of Eligibility" section under DEPENDENT COVERAGE and all the other terms of the policy; or
 - b) resides outside the United States. A Dependent Child who is attending school outside the United States will be deemed to be residing within the United States. A Dependent Child residing outside the United States but not attending school will not be insured as a Dependent unless approved by us in writing.]]

[[Domestic Partner

Domestic Partner means your unmarried opposite sex or same sex life partner who:

1. Is at least 18 years of age;
2. Is not married to or separated from anyone else under applicable state law;
3. Is not related to you by blood;
4. Resides with you in the same household and intends to do so indefinitely;
5. With you, is jointly responsible for your common welfare and basic financial obligations, demonstrated by such items as:
 - a) a joint mortgage or lease;
 - b) designation of the domestic partner as beneficiary for life insurance or retirement benefits;
 - c) joint wills (or designation of the domestic partner as executor and/or primary beneficiary);
 - d) designation of the domestic partner as having durable power of attorney or health care proxy;
 - e) ownership of joint bank account, credit cards or evidence of other joint financial responsibility.]]]

[Eligible Employee

Someone who under the terms of the policy:

1. Meets the requirements in the definition of Employee; and
2. Completes the waiting period (described in the "Date of Eligibility" section); and
3. Is working within the United States. An employee who is working on a temporary assignment outside the United States for a period of 12 months or less will be deemed to be working within the United States. An employee working outside the United States on other than a temporary assignment will not be considered an Eligible Employee unless approved by us in writing.

If your earnings from the Employer are reported to the Internal Revenue Service on Form 1099 or other form designated by the Internal Revenue Service to report payments to an independent contractor rather than payments to an employee, you will not be considered to be an Eligible Employee unless approved by us in writing.

Employee

Someone who meets the following requirements:

1. Is an employee of the Employer, as stated in PART 1: Insurance Schedule;
2. Regularly works at least 30 hours per week at the Employer's usual place of business or at such place or places that the Employer's normal course of business may require, unless otherwise stated in PART 1: Insurance Schedule;
3. Is paid for such work in accordance with applicable Wage and Hour Laws; and
4. Is in a classification eligible for insurance as shown in the Employer's Plan of Insurance or as noted in the Insurance Schedule, if applicable.

Employer (Eligible Employer)

The Policyholder shown on the first page.

[[Full-time Student

A Child who:

1. Is attending on a full-time basis a college or university licensed as such by the state in which it is located; and
2. Is enrolled for at least the minimum number of course credits required by such college or university to maintain standing as a full-time student.]]

Functioning Natural Tooth

The term "Functioning Natural Tooth" means that part of the tooth that is formed by the human body that:

1. Maintains arch length space;
2. Is utilized in the masticatory function; and
3. Is adequately supported by the surrounding structures.]

[[Handicapped Child

A Handicapped Child is a Child who may be insured beyond the applicable age limit shown above in the definition of Child, as long as:

1. Such a Child is:
 - a) unmarried;
 - b) incapable of self-sustaining employment by reason of:
 - i) mental retardation; or
 - ii) physical handicap;
 - c) dependent upon you for support and maintenance; and
 - d) insured:
 - i) under the policy upon attaining age 19; or
 - ii) under the policy prior to or upon attaining age 25, if such Child is a Full-time Student; or
 - iii) as a handicapped child under a group dental insurance plan of your Employer immediately prior to the date on which your Employer became an Eligible Employer; and
2. You submit on the Child's behalf due notice of such incapacity and dependency that is satisfactory to us. If such incapacity or dependency subsequently ceases, we must be notified.]]

[Incurred Date

A COVERED DENTAL EXPENSE will be considered incurred as follows:

1. With respect to Type I, Type II and Type III COVERED DENTAL EXPENSES only:
 - a) for full or partial dentures - on the date the final impression is made.
 - b) for fixed bridges, crowns, inlays, onlays - on the date of the final preparation of the teeth.
 - c) for root canal therapy - on the date the pulp chamber is opened.
 - d) for implants – on the date the implant is inserted.
 - e) for all other services - on the date the service is provided.
2. With respect to Type IV COVERED DENTAL EXPENSES only:
 - a) for cephalometric x-ray or study models - on the date the service was rendered.
 - b) for all other expenses - on the date of insertion of bands or appliance.

Late Entrant

Late Entrant means someone who:

1. Complies with the "Conditions of Insurability" for Dental Expense Benefits more than 31 days after he or she becomes eligible; or
2. Requests reinstatement of insurance which was terminated while he or she remained eligible for insurance under the policy.]

[[Non-PPO Expenses

A Covered Dental Expense for services that are furnished by a Non-PPO Provider.

Non-PPO Provider

Any Dentist who has not entered into a service agreement with [[us or with]] an organization with whom we have contracted to provide dental services at the pre-determined Schedule Charge.]]

[[Orthodontic Treatment

Means the corrective movement of teeth through bone by means of an active appliance to correct a malocclusion.]]

[Plan of Insurance

The Plan of Insurance/Benefits provided to your Employer, as maintained by Sun Life Assurance Company of Canada at its U.S. Headquarters.]

[[PPO

Preferred Provider Organization.

PPO Expenses

A Covered Dental Expense for services that are furnished by a PPO Provider.

PPO Provider

Any Dentist who has entered into a service agreement with us or with an organization with whom we have contracted to provide dental services at the pre-determined Schedule Charge.]]

Proof

Any information that is:

1. Required by us under the terms of the policy; and
2. Satisfactory to us.

[[Retired Employee

An Eligible Employee whose employment with the Employer has ended or ends due to retirement.]]

[[Schedule Amount

The amount payable by us for a given procedure. The list of Schedule Amounts for each procedure is shown in PART 5: COVERED DENTAL EXPENSES.]]

[[Schedule Charge

The pre-determined fee (that has been agreed to [[by us or]] by an organization with whom we have contracted and the PPO Provider) charged and received for a given service by the Dentist's office in the area where the charge for such service is made.]]

Usual Charge

The fee regularly charged and received for a given service by the Dentist's office.

We (we, us, Our, our)

Sun Life Assurance Company of Canada

You (you, Your, your)

The Employee.]

PART 3: DENTAL EXPENSE BENEFITS: EMPLOYEE INSURANCE

[Date of Eligibility (Waiting Period)]

You will be eligible for insurance on the date you complete the number of consecutive days or months of full-time continuous active service shown in the Insurance Schedule.

"Full-time continuous active service" means that you satisfy the Actively At Work definition at all times during said Waiting Period except that minor interruptions for a total period of not more than five days in the aggregate during such Waiting Period will be disregarded. If you were on an approved leave of absence granted in accordance with a State Family Leave Law or the Federal Family and Medical Leave Act (FMLA), you will be considered Actively At Work for the purpose of this provision, provided you were insured under the Employer's prior plan during this leave and continuation of coverage during this leave is based upon a uniform policy of your Employer and not individual selection.

If you elect to be covered under an alternate plan of dental benefits made available by your Employer, you will not be eligible for these Dental Expense Benefits.

Conditions of Insurability

To become insured under the policy you must:

1. Satisfy the Waiting Period shown in the Insurance Schedule;
2. Complete and submit one of our enrollment cards or, if applicable, one of the enrollment cards that we and your Employer have agreed to use in place of our enrollment cards; and
3. Agree to make any required contribution toward the cost of the insurance.

If you submit an enrollment card more than 31 days after the date you become an Eligible Employee, you are a Late Entrant with respect to Employee Insurance and you will be subject to the "Limitation on Late Entrants" section below.

[[Annual Election Period

During the Annual Election Period, you may elect to:

1. Purchase dental insurance; or
2. Cancel your dental insurance under the policy.]]

[[Annual Plan Selection Period

During the Annual Plan Selection Period, you may elect to become covered under an alternate plan of Dental Expense Benefits made available by the Employer and provided by us.]]

Effective Date of Insurance

Once you have met the Conditions of Insurability, you will be insured under the policy on the date you become eligible, provided you are Actively At Work on that date. Otherwise, you will be insured on the date you are again Actively At Work.

If you are not Actively At Work on such date solely because such date was not a regularly scheduled working day, you will be deemed Actively At Work on that date.

[[If you enroll during the Annual Election Period, you will be insured under the policy on the date determined by your Employer.]]

[[When Coverage Starts

If you become an Eligible Employee after the date your Employer becomes an Eligible Employer;

1. With respect to COVERED DENTAL EXPENSES provided by a PPO Provider, benefits are available for:
 - a. Type I COVERED DENTAL EXPENSES that are incurred after you become insured; and
 - b. Type II COVERED DENTAL EXPENSES that are incurred more than 6 months after you become insured; and
 - c. Type III COVERED DENTAL EXPENSES that are incurred more than 12 months after you become insured; and
 - d. Type IV COVERED DENTAL EXPENSES that are incurred more than 12 months after you become insured.
2. With respect to COVERED DENTAL EXPENSES provided by a Non-PPO Provider, benefits are available for:
 - a. Type I COVERED DENTAL EXPENSES that are incurred more than 12 months after you become insured; and
 - b. Type II COVERED DENTAL EXPENSES that are incurred more than 12 months after you become insured.
 - c. Type III COVERED DENTAL EXPENSES that are incurred more than 36 months after you become insured.
 - d. Type IV COVERED DENTAL EXPENSES that are incurred more than 36 months after you become insured.

If you are a Late Entrant, see "Limitation on Late Entrants" section below.]]]

[Limitation on Late Entrants

For the first 24 months that a Late Entrant is insured for these DENTAL EXPENSE BENEFITS, the benefits will be limited to the lesser of the benefits shown in items 1 and 2 below or those shown in the "When Coverage Starts" section, above:

1. Benefits for the first 12 months will be limited to Type I COVERED DENTAL EXPENSES.
2. Benefits for the second 12 months will be limited to Type I and Type II COVERED DENTAL EXPENSES

If you request reinstatement of insurance that was terminated while you remained eligible for such insurance under the policy, the above limitations will apply from the date on which such insurance is reinstated. Any time period for which such insurance was effective prior to such date cannot be used to satisfy the time limitations stated above.

Increases in Insurance

If for any reason there is an increase in the amount of insurance or benefits for which you are eligible, you will be insured for such increased amount or benefits on the date of the increase provided you are Actively At Work on that date. Otherwise, you will be insured for such increased amount or benefits on the date you are again Actively At Work.

If you are not Actively At Work on such date solely because such date was not a regularly scheduled working day, you will be deemed Actively At Work on that date.

Decreases in Insurance

If there is a decrease in the amount of insurance or benefits for which you are eligible, you will be insured for such decreased amount or benefits on the date of the decrease.]

[[PART 3A: DENTAL EXPENSE BENEFITS: DEPENDENT COVERAGE

Date of Eligibility

If you have at least one Dependent on the date you become insured for Employee Insurance, you will become eligible for Dependent Coverage on that date. If you do not have a Dependent on that date, you will become eligible for Dependent Coverage on the date that you acquire one. If you and your spouse [[or Domestic Partner]] are both insured as Employees of your Employer on the date you acquire a Dependent Child, then on such date, the Employee whose employment date with the Employer is the later of the two will be deemed a Dependent rather than an Employee, subject to all the terms of the policy.

Conditions of Insurability

To become insured with respect to a Dependent:

1. You must satisfy the Waiting Period shown in the Insurance Schedule;
2. You must be insured for Employee Insurance;
3. Your Employer must notify us that you have or have acquired such Dependent;
4. You must agree in writing to make any required contribution.
5. [[You must complete and submit for our approval, a [notarized] Affidavit of Domestic Partnership to become insured with respect to a Domestic Partner.]]

If any of the requirements in items 3, 4, [[or 5]] of this section are met more than 31 days from the date you become eligible for coverage for a Dependent or more than 31 days from the date your Child reaches age 3, you are a Late Entrant with respect to Dependent Coverage and you will be subject to the "Limitation on Late Entrants" section below.

[[Annual Election Period

During the Annual Election Period, you may elect to:

1. Purchase dental insurance; or
2. Cancel your dental insurance under the policy.]]

Effective Date of Insurance

Once you have met the Conditions of Insurability, you will be insured, with respect to your Dependent, as follows:

1. If your Dependent is not confined in any institution for medical care or treatment or confined at home or elsewhere, on the date you become eligible for Dependent Coverage; or
2. If your Dependent is so confined on the date you become eligible for Dependent Coverage, on the date that Dependent has ceased to be so confined and is now able to perform substantially all of the normal activities of a person of like age and sex in good health.

[[3. If you enroll your Dependent during the Annual Election Period, on the date determined by your Employer.]]

[[When Coverage Starts

If you become an Eligible Employee after the date your Employer becomes an Eligible Employer;

1. With respect to COVERED DENTAL EXPENSES provided by a PPO Provider, benefits are available for:
 - a. Type I COVERED DENTAL EXPENSES that are incurred after you become insured; and
 - b. Type II COVERED DENTAL EXPENSES that are incurred more than 6 months after you become insured; and
 - c. Type III COVERED DENTAL EXPENSES that are incurred more than 12 months after you become insured; and
 - d. Type IV COVERED DENTAL EXPENSES that are incurred more than 12 months after you become insured.
2. With respect to COVERED DENTAL EXPENSES provided by a Non-PPO Provider, benefits are available for:
 - a. Type I COVERED DENTAL EXPENSES that are incurred after you become insured; and
 - b. Type II COVERED DENTAL EXPENSES that are incurred more than 12 months after you become insured; and
 - c. Type III COVERED DENTAL EXPENSES that are incurred more than 36 months after you become insured; and
 - d. Type IV COVERED DENTAL EXPENSES that are incurred more than 36 months after you become insured.

If you are a Late Entrant, see "Limitation on Late Entrants" section below.]]

[[Limitation on Late Entrants

If you are a Late Entrant with respect to Dependent Coverage, benefits for the first 24 months of coverage for your Dependent will be limited to the lesser of the benefits shown in items 1 and 2 below or those shown in the "When Coverage Starts" section above:

1. Benefits for the first 12 months will be limited to Type I COVERED DENTAL EXPENSES.
2. Benefits for the second 12 months will be limited to Type I and Type II COVERED DENTAL EXPENSES.

If you request reinstatement of insurance with respect to Dependent Coverage that was terminated while you remained eligible for such coverage under the policy, the above limitations will apply from the date on which such coverage is reinstated. Any time periods for which such coverage was effective prior to such date cannot be used to satisfy the time limitations stated above.

Increases in Insurance

If there is an increase in the amount of insurance or benefits for which you are eligible with respect to your Dependent, your Dependent will be insured for such increased amount or benefits on the date of the increase.

Such Dependent, however, must not be confined in any institution for medical care or treatment or confined at home or elsewhere on that date. If the Dependent is so confined, such Dependent will be insured for such increased amount or benefits on the date he or she has ceased to be so confined and is now able to perform substantially all of the normal activities of a person of like age and sex in good health.

In addition, you must be insured for such increase under the terms of the "Increases in Insurance" section of EMPLOYEE INSURANCE before your Dependent can be eligible for such increase.

Decreases in Insurance

If there is a decrease in the amount of insurance or benefits for which you are eligible with respect to your Dependent, such Dependent will be insured for such decreased amount or benefits on the date of the decrease.]]

PART 4: DENTAL EXPENSE BENEFITS: DETERMINATION OF BENEFITS

[Pre-Determination of Benefits

Pre-Determination of Benefits is recommended for any of the services listed below. We recommend that the DENTAL TREATMENT PLAN be submitted to us for review before treatment begins. We will notify you and the Dentist of the benefits payable based upon the DENTAL TREATMENT PLAN. In determining the amount of benefits payable, consideration will be given to Alternate Dental Treatment that will, as determined by us, accomplish a professionally satisfactory result. If you and the Dentist agree to a more costly method of treatment, than that determined by us, the excess amount will not be paid by us. Failure to submit a Pre-Determination of Benefits does not affect the amount of benefits payable by us.

Pre-Determination of Benefits is recommended for the following:

1. Endodontic procedures including root canal therapy, hemisection, apicoectomy and retrograde filling;
2. Periodontal procedures including gingivectomy, provisional splinting, osseous surgery, osseous graft, occlusal adjustment, scaling and root planing;
3. Surgical procedures including alveoplasty, removal of a cyst, surgical extraction of erupted and impacted teeth, and incision and drainage;
4. Prosthetics including initial and replacement inlays, onlays, crowns, bridges, and partial or full dentures;
5. Orthodontic Treatment;
6. Any other services:
 - a) which will be rendered within 5 consecutive Business Days; and
 - b) for which charges will exceed \$500.

Conditions Under Which Benefits Are Payable

We will pay benefits as described below subject to the following:

1. Our payment of benefits described below is subject to all the terms and conditions of the policy;
2. We will not pay benefits for any one item of expense under more than one provision of the policy. All related dental expenses will be considered as part of the most comprehensive procedure and only the benefit for such procedure will be payable; and
3. The maximum amount that we will pay for:
 - a) Type I, Type II and Type III COVERED DENTAL EXPENSES combined is described in the "Calendar Year Maximum Benefit" section below; and
 - [[b) Type IV COVERED DENTAL EXPENSES is described in the "Lifetime Maximum Benefit" section below.]]
 - [[c) Type II, Type III and/or Type IV COVERED DENTAL EXPENSES is described in the "Calendar Year Maximum Benefit" section below.]]

Benefits Payable with respect to Type I, Type II and Type III COVERED DENTAL EXPENSES

If during a Calendar Year a Covered Person incurs COVERED DENTAL EXPENSES in excess of the Deductible, we will pay to you a benefit equal to the applicable percentage shown in the Insurance Schedule of Type I, Type II and/or Type III COVERED DENTAL EXPENSES incurred in excess of the applicable Deductible, subject to the Calendar Year Maximum Benefit.]

[[Benefits Payable For Type IV COVERED DENTAL EXPENSES

Upon receipt of Proof of claim that any Covered Person has incurred Type IV COVERED DENTAL EXPENSES:

1. The benefit payable will be:
 - a) equal to the percentage shown in the Insurance Schedule for Type IV COVERED DENTAL EXPENSES; and
 - b) limited to the Lifetime Maximum Benefit; and
 - [[c) limited to the Calendar Year Maximum Benefit; and]]
2. The benefit will be payable according to the following method:
 - a) the initial benefit payable will:
 - i) be determined by the amount of Type IV COVERED DENTAL EXPENSES for the diagnosis and/or placement of the bands or appliance; and
 - ii) not exceed 30% of the total benefit;
 - b) any remaining benefit for Type IV COVERED DENTAL EXPENSES incurred for monthly adjustments will be payable on a 3 month payment schedule as long as treatment continues and insurance is in force; and
 - c) in no event will the total benefit be payable in one sum at the start of treatment.]]

[Deductible

Any Per Person Deductible per [[Calendar Year]] [[Lifetime]] for each type of COVERED DENTAL EXPENSE [[and vision care expenses combined]] is shown in the Insurance Schedule. The amounts to be applied to meet the Deductible must be charges for COVERED DENTAL EXPENSES.

Amounts applied for your family will not exceed the Maximum Family Deductible shown in the Insurance Schedule in any Calendar Year, even if the Per Person Deductible has not been met.

[[The Per Person Deductible amounts for PPO and Non-PPO Expenses per Calendar Year for each type of COVERED DENTAL EXPENSE are shown in the Insurance Schedule. When Covered Dental Expenses are incurred, the applicable deductible (PPO or Non-PPO) must be met before any benefits are payable for those expenses. Covered Dental Expenses incurred toward the satisfaction of one of these deductibles (PPO or Non-PPO) in a Calendar Year will be applied toward the satisfaction of the other deductible (PPO or Non-PPO) for that year. The maximum Per Person Deductible for a Calendar Year will not exceed the Per Person Deductible amount for Non-PPO Expenses shown in the Insurance Schedule.

Amounts applied for your family in any Calendar Year will not exceed the Maximum Family Deductibles for PPO and Non-PPO Expenses that are shown in the Insurance Schedule, even if the Per Person Deductible has not been met.]]

If COVERED DENTAL EXPENSES are incurred in the last three months of a Calendar Year and are used to meet any or all of that Calendar Year's Deductible, the following Calendar Year's Deductible for that Covered Person will be reduced by the amount so applied.

Calendar Year Maximum Benefit

The Per Person Maximum Benefit in each Calendar Year for Type II, Type III or Type IV specifically and for Type I, Type II and Type III expenses [[and vision care expenses]] combined is shown in the Insurance Schedule. Only Type II, III, or IV Expenses will be applied toward the Type II, Type III or Type IV Maximum Benefit. The Calendar Year Maximum Benefit applies to all periods of time the Covered Person is insured during a Calendar Year regardless of any interruption in coverage for this insurance. This Maximum Benefit applies to all COVERED DENTAL EXPENSES whether they are PPO or Non-PPO Expenses.

[[The Maximum Family Benefit in each Calendar Year for Type I, Type II, and Type III expenses combined is shown in the Insurance Schedule.]]

[[The Per Person Maximum Benefit amounts for PPO and Non-PPO Expenses in each Calendar Year for Type I, Type II and Type III expenses combined are shown in the Insurance Schedule.

Only PPO Expenses will be applied toward the Per Person Maximum Benefit for PPO Expenses. Only Non-PPO Expenses will be applied toward the Per Person Maximum Benefit for Non-PPO Expenses.

The Per Person Maximum Benefit for PPO and Non-PPO Expenses combined is shown in the Insurance Schedule.]]

The Maximum Benefit applies to all periods of time the Covered Person is insured during a Calendar Year regardless of any interruptions in coverage for this insurance.]

[[Maximum Carryover

If benefits paid in a Calendar Year for Type II and III Covered Dental Expenses do not exceed the Threshold, the Covered Person will establish a Carryover Account. The account may be used for added benefit payments in subsequent Calendar Years. When the Covered Person incurs Covered Dental Expenses in excess of the Calendar Year Maximum Benefit, benefits will be payable from the Carryover Account. The account will then be reduced by the amount of any benefits payable that are in excess of the Calendar Year Maximum Benefit.

The Threshold in any Calendar Year is \$500. If the Threshold is not met in any Calendar Year, \$350 will be added to the Carryover Account for that year. However, the Carryover Account is subject to a maximum of \$1,000. In any Calendar Year where the Threshold is met by the Covered Person, there will be no addition to the Carryover Account for that year.

The Maximum Carryover provision will begin in the first Calendar Year in which a Covered Person submits a claim.

If the Employer's coverage or a Covered Person's coverage first becomes effective after September 30th of any year, the Maximum Carryover provision will not apply until the next Calendar Year. Only claims for Type II and III Covered Dental Expenses that are incurred on or after January 1st of the next Calendar Year will count toward the Threshold. Amounts applied toward the Carryover Account may not be used until the Calendar Year that starts one year from the date the Maximum Carryover provision first applies.

If charges for any Type II or III Covered Dental Expenses are not payable because a Covered Person is subject to the Limitation on Late Entrants provision or the When Coverage Starts provision, the Maximum Carryover provision will not apply until benefits are available for those expenses. In addition, if such benefits are not available until after September 30th of any year, the Maximum Carryover provision will not apply until the next Calendar Year.

A Covered Person's Account will be eliminated if he or she has a break in coverage for any length of time, for any reason.

[[The Maximum Carryover provision is not applicable to [[Type IV Expenses or to]] benefits payable for bleaching or veneers which are cosmetic in nature.]]

For the purposes of this provision the following definitions apply:

Threshold - The maximum amount of benefits for Type II and Type III Covered Dental Expenses that a Covered Person can receive in a Calendar Year and still be eligible for an addition to his Carryover Account for that year. The Threshold amount is \$500.

Carryover Account – The amount of added benefits for Types I, II, and III Covered Dental Expenses, that a Covered Person has accrued by not exceeding the Threshold in any Calendar Year. The accrued benefits in the account will be payable in any Calendar Year in which a Covered Person exceeds the Calendar Year Maximum Benefit. A person may accrue benefits up to \$350 in a Calendar Year. The maximum amount of benefits that may be accrued in the account is \$1,000. Each Covered Person is eligible for a Carryover Account.]]

[[Lifetime Maximum Benefit

The Lifetime Maximum Benefit payable for any Covered Person who incurs Type IV [[and Vision Care]] expenses is shown in the Insurance Schedule. The Lifetime Maximum Benefit applies to all periods of time the Covered Person is insured for DENTAL EXPENSE BENEFITS under the policy regardless of any interruptions in coverage for this insurance. This Maximum Benefit applies to all Type IV COVERED DENTAL EXPENSES whether they are PPO or Non-PPO Expenses.

[[The Per Person Lifetime Maximum Benefit amounts for PPO and Non-PPO Type IV expenses are shown in the Insurance Schedule. Only PPO Expenses will be applied toward the Per Person Lifetime Maximum Benefit for PPO Expenses. Only Non-PPO Expenses will be applied toward the Per Person Lifetime Maximum Benefit for Non-PPO Expenses. The Per Person Lifetime Maximum Benefit for PPO and Non-PPO Expenses combined is shown in the Insurance Schedule. The Lifetime Maximum Benefit applies to all periods of time the Covered Person is insured for DENTAL EXPENSE BENEFITS under the policy regardless of any interruptions in coverage for this insurance.]]]]

[[Lifetime Maximum Benefit

[[The Lifetime Maximum Benefit payable for any Covered Person who incurs Type IV Covered Dental Expenses will be whichever one of the following amounts is applicable. Only one such amount will be payable while such Covered Person is insured under the terms of the DENTAL EXPENSE BENEFITS:

1. For Type IV Covered Dental Expenses incurred by a Covered Person who is a Late Entrant, or by a Covered Person who has been insured under this certificate for 24 months, the Lifetime Maximum Benefit amount shown in the Insurance Schedule.
2. For Type IV Covered Dental Expenses incurred in the first 12 months such Covered Person is insured under this Certificate, 25% of the Lifetime Maximum Benefit amount shown in the Insurance Schedule; or
3. For Type IV Covered Dental Expenses incurred in the second 12 months such Covered Person is insured under this Certificate, 50% of the Lifetime Maximum Benefit amount shown in the Insurance Schedule.

The Lifetime Maximum Benefit applicable will be determined by the date of insertion of the bands or appliance.]]

The Lifetime Maximum Benefit applies to all periods of time the Covered Person is insured for DENTAL EXPENSE BENEFITS under the policy regardless of any interruptions in coverage for this insurance.

[[This Maximum Benefit applies to all Type IV COVERED DENTAL EXPENSES whether they are PPO or Non-PPO Expenses.]]]]

[Alternate Dental Treatment

If we determine that alternate procedures, services or courses of treatment can be performed to correct a dental condition, payment will be considered for the least costly procedure which we determine will produce a professionally satisfactory result.

Favorable Result of Treatment

Benefits will be considered only for treatment that we determine has a reasonably favorable prognosis.

Benefits For Temporary Work

Benefits for temporary dental service (including temporary prosthetics) will be considered a part of the final dental service. Benefits paid for the temporary service will be deducted from the benefits otherwise payable for the final service. By temporary prosthetics we mean any prosthetic inserted and utilized by a Covered Person for fewer than 12 months. Any prosthetic inserted and utilized by a Covered Person for at least 12 months will be considered permanent in nature and item 5 of EXCLUSIONS will apply.]

[Benefits After Termination of Insurance

1. Except as described in items 2 and 3 below, no benefits are available for:
 - a) Type I, Type II and Type III COVERED DENTAL EXPENSES incurred after a Covered Person's insurance ends.
 - [[b) Type IV COVERED DENTAL EXPENSES incurred after the last day of the calendar month in which coverage terminates.]]
2. Benefits are available for Type II and Type III COVERED DENTAL EXPENSES incurred while a Covered Person is insured; and completed within 30 days after the Covered Person's insurance ends. This extension is limited to crowns, fixed bridges, inlays, onlays, full dentures, partial dentures and root canal therapy. A pre-determination for any Dental Treatment Plan does not constitute treatment started.
- [[3. If the insurance of a Dependent Child, who is a Covered Person, terminates because he/she attains age 19 or attains age 25 [[if such Child is a Full-time Student]], Type IV COVERED DENTAL EXPENSES will continue to be paid if:
 - a) the appliance or bands were inserted while the Dependent Child was:
 - i) under age 19[[or
 - ii) under age 25, if such Child was a Full-time Student;]]
 - b) Orthodontic Treatment continues in accordance with the Dental Treatment Plan approved by us; and
 - c) you continue to be insured for DENTAL EXPENSE BENEFITS.]]]

[PART 5: DENTAL EXPENSE BENEFITS: COVERED DENTAL EXPENSES

A COVERED DENTAL EXPENSE is:

1. [[With respect to services rendered by a PPO Provider,]] the lesser of the Usual Charge or the Schedule Charge;
2. [[With respect to [[Type II and]] [[Type III]] [[and Type IV]] services rendered by a Non-PPO Provider, the lesser of the Usual Charge or the Customary Charge [[or the Schedule Charge]] [[or the Allowable Charge;]] [[and]]
3. [[With respect to Type I [[and Type II]] services rendered by a Non-PPO Provider, the lesser of the Usual Charge or the Customary Charge;]]

for any of the dental services listed below, when those services are performed by a Dentist or Dental Hygienist and are essential, as determined by us, for the necessary dental care of a Covered Person, and which have a favorable prognosis, as determined by us.

The following is a complete list of those dental services which will be considered as COVERED DENTAL EXPENSES; however, expenses that are incurred for the performance of any dental service not listed below will be considered a COVERED DENTAL EXPENSE only if we agree in writing to accept such expenses as COVERED DENTAL EXPENSES. If we so agree, the benefit that we pay will be consistent, as determined by us, with a payment for such similar COVERED DENTAL EXPENSES that would provide the least costly professionally adequate treatment.

Type I Dental Services

Service	Special Limitations
Oral Evaluation	Limited to <u>1</u> time in any <u>36</u> consecutive month period. Benefits will be based on the covered amount for a periodic oral evaluation.
Consultation	Paid as a separate benefit only if no other service, except x-rays, was rendered during the visit. Limited to <u>1</u> time in any <u>12</u> consecutive month period.
Bite-Wing X-rays	Limited to <u>1</u> time in any <u>36</u> consecutive month period.
Dental Prophylaxis	Limited to <u>1</u> time in any <u>36</u> consecutive month period and to Covered Persons age <u>14</u> and older for adult prophylaxis and to Covered Persons under age <u>14</u> for child prophylaxis. Not payable in addition to periodontal maintenance.
Fluoride Treatments	Limited to <u>1</u> time in any <u>36</u> consecutive month period and to Covered Persons under the age of <u>14</u> .
Space Maintainers	Limited to Covered Persons under the age of <u>14</u> . Benefits include all adjustments within <u>6</u> consecutive months of installation.
Sealants	Limited to Covered Persons under age <u>14</u> and to occlusal surfaces of permanent first and second molars and first and second bicuspid and to <u>1</u> time per tooth in any <u>60</u> consecutive month period.]

[Type II Dental Services

[[[A Covered Person] will not be eligible for Type II COVERED DENTAL EXPENSES until you have been insured under the policy for at least 12 consecutive months.]]

[[With respect to services rendered by a PPO Provider, [a Covered Person] will not be eligible for Type II COVERED DENTAL EXPENSES until you have been insured under the policy for at least 6 consecutive months.]]

[[With respect to services rendered by a non-PPO Provider, [a Covered Person] will not be eligible for Type II COVERED DENTAL EXPENSES until you have been insured under the policy for at least 12 consecutive months.]]

Service	Special Limitations
Occlusal Guard	Covered only for the treatment of bruxism or grinding. Not covered for the treatment of myofacial pain or TMJ. Limited to 1 appliance in any <u>36</u> consecutive month period. Benefits include all repairs and adjustments within <u>12</u> consecutive months of installation and then not more than <u>1</u> time in any <u>12</u> consecutive month period.
Oral Evaluation – Problem Focused	Paid as a separate benefit only if no other service, except x-rays, was rendered during the visit. Limited to <u>1</u> time in any <u>6</u> consecutive month period.
Extraoral X-rays	Limited to <u>1</u> film in any <u>12</u> consecutive month period.
Palliative Treatment including Sedative Fillings	Paid as a separate benefit only if no other service, except x-rays or problem-focused oral evaluation, was rendered during the visit.
Diagnostic Casts	Limited to 1 time in any <u>48</u> consecutive month period.
Simple Extraction	
Complete Series or Panorex X-rays	Limited to <u>1</u> panorex or complete series in any <u>60</u> consecutive month period. 10 or more individual periapical x-rays and/or bitewing films will be considered as a complete series for benefit purposes.
Occlusal X-rays	
Individual Periapical X-rays	Limited to <u>4</u> films in any <u>12</u> consecutive month period.
Arthrogram and other TMJ Films	Limited to 1 film in any 36 consecutive month period.
Amalgam Restorations	Limited to 1 time per tooth surface in any <u>12</u> consecutive month period. Restorations involving multiple surfaces will be combined for benefit purposes and paid according to the number of discrete surfaces treated.
Pin Retention	Limited to 1 time per restoration; not covered in addition to cast restorations.
Resin-based Composite Restorations	Limited to 1 time per tooth surface in any <u>12</u> consecutive month period. Restorations on posterior teeth will be paid as an amalgam restoration.
Stainless Steel Crowns	Limited to 1 time per tooth. Deciduous teeth only. Charges that exceed those payable for base metal will not be Covered Expenses.
Re-cement Cast Post	
Re-cement Inlays	
Re-cement Crowns	
Re-cement Bridges	
Repairs to Full Dentures, Partial Dentures, Bridges	Limited to repairs or adjustments of that appliance done more than <u>24</u> months after the initial insertion.
Hemisection	
Pulpotomy	Limited to deciduous teeth only.
Root Canal Therapy	Limited to 1 time per tooth in any <u>48</u> consecutive month period.]

【 Apicoectomy and Retrograde Filling】	
Scaling and Root Planing	Limited to <u>1</u> time per quadrant of the mouth in any <u>48</u> consecutive month period.
Periodontal Maintenance	Limited to <u>1</u> time in any <u>6</u> consecutive month period. Not payable in addition to dental prophylaxis.
Provisional Splinting	Limited to 1 time per area of the mouth in any 24 consecutive month period. Benefits include all repairs within that 24 month period.
Biopsy	
Alveoplasty	Not covered as a separate expense when rendered with a single extraction.
Incision and Drainage	
Removal of a Cyst	Not payable in addition to extraction performed in the same site on the same date.
Therapeutic Parenteral Drug Administration	
Surgical Extraction of Erupted Teeth and Impacted Teeth	
General Anesthesia	Will be paid for as a separate procedure only when required for extraction of impacted teeth, if such extraction is a Covered Expense.
Gingivectomy, Osseous Surgery, Osseous Graft	Only one of these procedures is covered per area of the mouth, in any <u>36</u> consecutive months.
Occlusal Adjustment	Covered only when performed within 3 months following periodontal surgery. Limited to one time per area of the mouth in any <u>36</u> consecutive month period. 】

[Type III Dental Services

[[[A Covered Person] will not be eligible for Type III COVERED DENTAL EXPENSES until you have been insured under the policy for at least 12 consecutive months.]]

[[With respect to services rendered by a PPO Provider, [a Covered Person] will not be eligible for Type III COVERED DENTAL EXPENSES until you have been insured under the policy for at least 12 consecutive months.]]

[[With respect to services rendered by a non-PPO Provider, [a Covered Person] will not be eligible for Type III COVERED DENTAL EXPENSES until you have been insured under the policy for at least 36 consecutive months.]]

Service	Special Limitations
Initial Inlays and Onlays	Covered only when the tooth cannot be restored by an Amalgam or Resin-based Composite Restoration.
Replacement of Inlays and Onlays	See item 5 of EXCLUSIONS.
Porcelain Restorations	Covered only if the tooth cannot be restored by an Amalgam or Resin-based Composite Restoration or by other means.
Crown Buildup or Core Buildup	See item 5 of EXCLUSIONS. Will be paid as a separate procedure only when required for placement of a crown, if such crown is a Covered Expense.
Initial Crowns	Covered only if the tooth cannot be restored by a filling or by other means. Crowns are not covered if placed for the purpose of periodontal splinting. Charges that exceed those payable for base metal will not be Covered Expenses.
Replacement Crowns	Charges that exceed those payable for base metal will not be Covered Expenses. See item 5 of EXCLUSIONS.
Replacement Implant Crowns	Charges that exceed those payable for base metal will not be Covered Expenses. See item 5 of EXCLUSIONS.
Implant Crown	Charges that exceed those payable for base metal will not be Covered Expenses. See item 7 of EXCLUSIONS.
Implant	Limited to one per missing tooth. See item 7 of EXCLUSIONS.
Cast Post and Core	Covered only for teeth that have had root canal therapy.
Initial Full or Partial Dentures	Charges that exceed those payable for base metal will not be Covered Expenses. See item 7 of EXCLUSIONS.
Relining Dentures	Limited to relining done more than <u>12</u> months after the initial insertion and then not more than 1 time in any 24 consecutive month period.
Rebasing Dentures	Limited to rebasing done more than <u>12</u> months after the initial insertion and then not more than 1 time in any 24 consecutive month period.
Replacement of Full or Partial Dentures	Charges that exceed those payable for base metal will not be Covered Expenses. See item 5 of EXCLUSIONS.
Initial Fixed Bridges	Charges that exceed those payable for base metal will not be Covered Expenses. Bridges will be paid as Partial Dentures. See item 7 of EXCLUSIONS.
Replacement of Fixed Bridges	Charges that exceed those payable for base metal will not be Covered Expenses. Bridges will be paid as Partial Dentures. See item 5 of EXCLUSIONS.
Root Recovery	
Frenectomy]	

[Type IV Orthodontic Dental Services

[[[A Covered Person] will not be eligible for Type IV COVERED DENTAL EXPENSES until you have been insured under the policy for at least 24 consecutive months.]]

[[With respect to services rendered by a PPO Provider, [a Covered Person] will not be eligible for Type IV COVERED DENTAL EXPENSES until you have been insured under the policy for at least 12 consecutive months.]]

[[With respect to services rendered by a non-PPO Provider, [a Covered Person] will not be eligible for Type IV COVERED DENTAL EXPENSES until you have been insured under the policy for at least 36 consecutive months.]]

Service	Special Limitations
Cephalometric X-ray	Limited to 1 time in any 2 year period.
Orthodontic Treatment	Limited to malocclusions as determined by us.
Study Models	Limited to 1 set of Study Models per Covered Person.]

[PART 5: DENTAL EXPENSE BENEFITS: COVERED DENTAL EXPENSES

[A COVERED DENTAL EXPENSE is:

[[1. With respect to Type I, II and III Dental Services,]] the lesser of the Usual Charge or the Customary Charge or the Schedule Amount;

[[2. With respect to Type IV Dental Services, the lesser of the Usual Charge or the Customary Charge;]]

for any of the dental services listed below, when those services are performed by a Dentist or Dental Hygienist and are essential, as determined by us, for the necessary dental care of a Covered Person, and which have a favorable prognosis, as determined by us.

The following is a complete list of those dental services which will be considered as COVERED DENTAL EXPENSES; however, expenses that are incurred for the performance of any dental service not listed below will be considered a COVERED DENTAL EXPENSE only if we agree in writing to accept such expenses as COVERED DENTAL EXPENSES. If we so agree, the benefit that we pay will be consistent, as determined by us, with a payment for such similar COVERED DENTAL EXPENSES that would provide the least costly professionally adequate treatment.

Type I Dental Services

ADA CODE	DENTAL PROCEDURE	SCHEDULE AMOUNT
	Oral Evaluations (Limited to 1 time in any 36 consecutive month period)	
D0120	Periodic oral evaluation	\$ <u>11.00 - \$78.00</u>
D0145	Oral evaluation for patient under three years of age and counseling with primary caregiver	<u>11.00 - 78.00</u>
D0150	Comprehensive oral evaluation - new or established patient	<u>18.00 - 118.00</u>
D0180	Comprehensive periodontal evaluation - new or established patient	<u>22.00 - 150.00</u>
	X-Rays – Coverage is provided for either a complete series of x-rays or a panoramic film once in any <u>60</u> consecutive month period. Coverage for individual periapical x-rays is limited to <u>4</u> films in any <u>12</u> consecutive month period. Coverage for bitewing x-rays is limited to <u>1</u> time in any <u>36</u> consecutive month period. Coverage for extraoral x-rays is limited is limited to 1 time in any <u>36</u> consecutive month period.	
D0210	Intraoral - complete series (including bitewings)	<u>31.00 - 176.00</u>
D0220	Intraoral - periapical - first film	<u>6.00 - 38.00</u>
D0230	Intraoral - periapical each additional film	<u>5.00 - 30.00</u>
D0240	Intraoral - occlusal film	<u>10.00 - 60.00</u>
D0250	Extraoral - first film	<u>14.00 - 75.00</u>
D0260	Extraoral - each additional film	<u>13.00 - 60.00</u>
D0270	Bitewing - single film	<u>7.00 - 40.00</u>
D0272	Bitewings - two films	<u>10.00 - 60.00</u>
D0274	Bitewings - four films	<u>14.00 - 80.00</u>
D0277	Vertical bitewings - 7 to 8 films	<u>25.00 - 120.00</u>
D0330	Panoramic Film	<u>27.00 - 150.00</u>
D0310	Sialography	<u>33.00 - \$ 180.00]</u>

[Type I Dental Services

ADA CODE	DENTAL PROCEDURE	SCHEDULE AMOUNT
D1110	Prophylaxis – Adult (Limited to <u>1</u> time in any <u>36</u> consecutive month period and to Covered Persons age <u>14</u> and older). [[Not payable in addition to periodontal maintenance.]]	\$ <u>22.00 – \$ 118.00</u>
D1120	Prophylaxis - Child (Limited to 1 time in any 36 consecutive month period and to Covered Persons under age <u>14</u> .)	<u>17.00 – 100.00</u>
	Fluoride Treatments - Limited to <u>1</u> time in any <u>36</u> consecutive month period and to Covered Persons under the age of <u>14</u> .	
D1201	Topical Application of Fluoride (including prophylaxis) - Child	<u>24.00 – 120.00</u>
D1203	Topical Application of Fluoride (not including prophylaxis) - Child	<u>9.00 – 65.00</u>
	[[Space Maintainers - Limited to Covered Persons under the age of <u>14</u> . Benefits include all adjustments within <u>6</u> consecutive months of installation.	
D1510	Space Maintainer - fixed - unilateral	<u>88.00 – 500.00</u>
D1515	Space Maintainer - fixed - bilateral	<u>115.00 – 550.00</u>
D1520	Space Maintainer – removable – unilateral	<u>108.00 – 500.00</u>
D1525	Space Maintainer – removable – bilateral	<u>149.00 – 1,179.00</u>
D1550	Recement Space Maintainer	<u>19.00 – 112.00</u>
D1555	Removal of fixed space maintainer by provider/practice that did not place space maintainer	<u>27.00 – 164.00]]</u>
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	<u>36.00 – 240.00</u>
[[D1351	Sealant – per tooth. Limited to Covered Persons under age <u>14</u> and to occlusal surfaces of permanent first and second molars and first and second bicuspid and to <u>1</u> time per tooth in any <u>60</u> consecutive month period.	<u>14.00 – 80.00]]</u>
D0460	Pulp Vitality Tests	<u>14.00 – 100.00]</u>

[Type II Dental Services

ADA CODE	DENTAL PROCEDURE	SCHEDULE AMOUNT
	Oral Evaluations- Problem focused - (Limited to <u>1</u> time in any <u>36</u> consecutive month period.)	
D0160	Detailed and extensive oral evaluation - problem focused	<u>\$ 49.00 – \$ 170.00</u>
D0170	Re-evaluation - limited, problem focused (Established patient; not post-operative visit)	<u>15.00 - 95.00</u>
D0140	Limited oral evaluation – problem focused (Paid as a separate benefit only if no other service, except x-rays, was rendered during the visit. Limited to <u>1</u> time in any <u>6</u> consecutive month period.)	<u>13.00 – 35.00</u>
D0290	Posterior-anterior or lateral skull and facial bone survey film	<u>38.00 – 108.00</u>
	Arthrograph and other TMJ films – Limited to 1 film in any 36 consecutive month period.	
D0320	Temporomandibular joint arthrograph, including injection	<u>31.00 – 189.00</u>
D0321	Other temporomandibular joint films	<u>27.00 – 162.00</u>
D0322	Tomographic survey	<u>29.00 – 162.00</u>
D0340	Cephalometric film – Limited to 1 time in any 2 year period.	<u>29.00 – 135.00</u>
D0470	Diagnostic Casts (Limited to 1 time in any <u>48</u> consecutive month period.)	<u>23.00 – 170.00</u>
	Restorations – Limited to <u>1</u> time per tooth surface in any <u>36</u> consecutive month period. Restorations involving multiple surfaces will be combined for benefit purposes and paid according to the number of discrete surfaces treated. [[Resin-based restorations on posterior teeth will be paid as an amalgam restoration.]]	
D2140	Amalgam - one surface, primary or permanent	<u>22.00 – 162.00</u>
D2150	Amalgam - two surfaces, primary or permanent	<u>29.00 – 198.00</u>
D2160	Amalgam - three surfaces, primary or permanent	<u>36.00 – 248.00</u>
D2161	Amalgam - four or more surfaces, primary or permanent	<u>45.00 – 270.00</u>
D2330	Resin-based composite - one surface, anterior	<u>28.00 – 180.00</u>
D2331	Resin-based composite - two surfaces, anterior	<u>36.00 – 234.00</u>
D2332	Resin-based composite - three surfaces, anterior	<u>44.00 – 278.00</u>
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	<u>52.00 – 360.00</u>
D2390	Resin-based composite crown, anterior	<u>64.00 – 405.00</u>
[[D2391	Resin-based composite - one surface, posterior	<u>33.00 – 195.00</u>
D2392	Resin-based composite - two surfaces, posterior	<u>46.00 – 248.00</u>
D2393	Resin-based composite - three surfaces, posterior	<u>57.00 – 304.00</u>
D2394	Resin-based composite - four or more surfaces, posterior	<u>68.00 – 382.00]]</u>
D2410	Gold foil – 1 surface	<u>22.00 – 162.00</u>
D2420	Gold foil – 2 surfaces	<u>29.00 – 198.00</u>
D2430	Gold foil – 3 surfaces	<u>36.00 – 248.00</u>
D2910	Recement Inlay, onlay, or partial coverage restoration	<u>21.00 – 113.00</u>
D2915	Recement cast or prefabricated post and core	<u>21.00 – 135.00</u>
D2920	Recement Crown	<u>21.00 – 135.00</u>
D2930	Prefabricated Stainless Steel Crown – Primary tooth – Limited to 1 time per tooth.	<u>56.00 – 250.00]]</u>

[Type II Dental Services

ADA CODE	DENTAL PROCEDURE	SCHEDULE AMOUNT
D2934	Prefabricated esthetic coated stainless steel crown – Primary tooth	\$ <u>90.00 – \$ 250.00</u>
D2951	Pin Retention – per tooth, in addition to crown. Limited to 1 time per restoration; not covered in addition to cast restorations.	<u>12.00 – 53.00</u>
D2980	Crown repair, by report	<u>36.00 – 338.00</u>
[[D4910	Periodontal Maintenance Limited to <u>1</u> time in any <u>12</u> consecutive month period. [[Not payable in addition to dental prophylaxis.]]	<u>34.00 – 179.00]]</u>
	Repairs and adjustments to dentures or bridges – Limited to repairs or adjustments done more than <u>24</u> months after the initial insertion.	
D5410	Adjust Complete Denture - maxillary	<u>17.00 – 99.00</u>
D5411	Adjust Complete Denture - mandibular	<u>17.00 – 90.00</u>
D5421	Adjust Partial Denture – maxillary	<u>17.00 – 99.00</u>
D5422	Adjust Complete Denture - mandibular	<u>17.00 – 90.00</u>
D6930	Recement fixed partial denture	<u>26.00 – 176.00</u>
D6092	Recement implant/abutment supported crown	<u>21.00 – 1,569.00</u>
D6093	Recement implant/abutment supported fixed partial denture	<u>26.00 – 1,946.00</u>
D6091	Replacement of semi-precision or precision attachment or implant/abutment supported prosthesis, per attachment	<u>51.00 – 1,569.00</u>
D6980	Fix partial denture, by report	<u>51.00 – 450.00</u>
D6985	Pediatric Partial Denture, fixed	<u>244.00 – 495.00</u>
D9120	Fixed partial denture sectioning	<u>23.00 – 138.00</u>
D7111	Extraction coronal remnant- deciduous tooth	<u>20.00 – 135.00</u>
D7140	Extraction erupted tooth or exposed root	<u>28.00 – 185.00</u>
D9110	Palliative (emergency) treatment of dental pain – minor procedure. Paid as a separate benefit only if no other service, except x-rays, was rendered during the visit.	<u>19.00 – 171.00</u>
D9310	Consultation (diagnostic service by dentist other than practitioner providing treatment). Limited to <u>1</u> time in any <u>12</u> consecutive month period.	<u>34.00 – 273.00</u>
D9910	Application of desensitizing medicament	<u>9.00 – 68.00</u>
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	<u>6.00 – 54.00</u>
	Occlusal guard. Covered only for the treatment of bruxism or grinding. Limited to 1 appliance in any <u>36</u> consecutive month period. Benefits include all repairs and adjustments within 12 consecutive months of installation and then not more than 1 time in any 12 consecutive month period.	
D9940	Occlusal guard, by report	<u>152.00 – 546.00</u>
D9942	Repair and/or reline of occlusal guard	<u>43.00 – 360.00</u>
	Occlusal adjustment - Covered only when performed within 3 months following periodontal surgery. Limited to one time per area of the mouth in any <u>36</u> consecutive month period.	
D9951	Occlusal adjustment – limited	<u>27.00 – 173.00</u>
D9952	Occlusal adjustment – complete	<u>148.00 – 1,080.00]</u>

[Type III Dental Services

ADA CODE	DENTAL PROCEDURE	SCHEDULE AMOUNT
	[[Implants -See items 5 and 7 of EXCLUSIONS.	
D6010	Surgical placement or implant body: endosteal implant	<u>\$ 428.00 – \$ 2,250.00</u>
D6040	Surgical placement: eposteal implant	<u>428.00 – 2,250.00</u>
D6050	Surgical placement: transosteal implant	<u>428.00 – 2,250.00]]</u>
	[Initial Inlays and Onlays – Covered only if the tooth cannot be restored by an Amalgam or Resin-based Composite Restoration or by other means.	
D2510	Inlay - metallic - one surface	<u>95.00 - 612.00</u>
D2520	Inlay - metallic - two surfaces	<u>105.00 – 660.00</u>
D2530	Inlay - metallic - three or more surfaces	<u>120.00 – 766.00</u>
D2542	Onlay - metallic - two surfaces	<u>118.00 – 720.00</u>
D2543	Onlay - metallic - three surfaces	<u>123.00 – 750.00</u>
D2544	Onlay - metallic - four or more surfaces	<u>129.00 – 810.00</u>
D2610	Inlay - porcelain/ceramic - one surface	<u>109.00 – 803.00</u>
D2620	Inlay - porcelain/ceramic - two surfaces	<u>115.00 – 810.00</u>
D2630	Inlay - porcelain/ceramic - three or more surfaces	<u>131.00 – 645.00</u>
D2642	Onlay - porcelain/ceramic - two surfaces	<u>121.00 – 750.00</u>
D2643	Onlay - porcelain/ceramic - three surfaces	<u>128.00 – 810.00</u>
D2644	Onlay - porcelain/ceramic - four or more surfaces	<u>136.00 – 720.00</u>
D2650	Inlay - resin-based composite - one surface	<u>171.00 – 839.00</u>
D2651	Inlay - resin-based composite - two surfaces	<u>171.00 – 839.00</u>
D2652	Inlay - resin-based composite - three or more surfaces	<u>171.00 – 839.00</u>
D2662	Onlay - resin-based composite - two surfaces	<u>93.00 – 995.00</u>
D2663	Onlay - resin-based composite - three surfaces	<u>115.00 – 995.00</u>
D2664	Onlay - resin-based composite - four or more surfaces	<u>123.00 – 995.00</u>
	Crowns – Initial crowns are covered only if the tooth cannot be restored by a filling or by other means. Crowns are not covered if placed for the purpose of periodontal splinting.	
D2710	Crown - resin-based composite (indirect)	<u>59.00 – 324.00</u>
D2712	Crown - 3/4 resin-based composite (indirect)	<u>132.00 – 32.00</u>
D2720	Crown - resin with high noble metal	<u>123.00 – 623.00</u>
D2721	Crown - resin with predominantly base metal	<u>123.00 – 623.00</u>
D2722	Crown - resin with noble metal	<u>123.00 – 623.00</u>
D2740	Crown - porcelain/ceramic substrate	<u>139.00 – 1,080.00</u>
D2750	Crown - porcelain fused to high noble metal	<u>137.00 – 750.00</u>
D2751	Crown - porcelain fused to predominantly base metal	<u>128.00 – 810.00</u>
D2752	Crown - porcelain fused to noble metal	<u>131.00 – 656.00</u>
D2780	Crown - 3/4 cast high noble metal	<u>133.00 – 756.00</u>
D2781	Crown - 3/4 cast predominantly base metal	<u>126.00 – 810.00</u>
D2782	Crown - 3/4 cast noble metal	<u>128.00 – 656.00</u>
D2783	Crown - 3/4 cast porcelain/ceramic	<u>135.00 – 900.00</u>
D2790	Crown - full cast high noble metal	<u>132.00 – 837.00</u>
D2791	Crown - full cast predominantly base metal	<u>125.00 – 837.00]</u>

[Type III Dental Services

ADA CODE	DENTAL PROCEDURE	SCHEDULE AMOUNT
D2792	Crown - full cast noble metal	<u>\$ 128.00 – \$ 765.00</u>
D2794	Crown - titanium	<u>137.00 – 765.00</u>
D2950	Core buildup including any pins	<u>31.00 – 210.00</u>
D2952	Cast post and core in addition to crown	<u>51.00 – 325.00</u>
D2953	Each additional cast post - same tooth	<u>11.00 – \$ 71.00</u>
D2954	Prefabricated post and core in addition to crown	<u>39.00 – 216.00</u>
D2957	Each additional prefabricated post - same tooth	<u>9.00 – 62.00</u>
D2960	Labial veneer (resin laminate) - chairside	<u>105.00 – 417.00</u>
D2961	Labial veneer (resin laminate) - laboratory	<u>117.00 – 621.00</u>
D2962	Labial veneer (porcelain laminate) - laboratory	<u>130.00 – 900.00</u>
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	<u>22.00 – 120.00</u>
D3221	Pulpal debridement, primary and permanent teeth	<u>24.00 – 158.00</u>
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	<u>23.00 – 285.00</u>
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	<u>25.00 – 168.00</u>
	Root Canal Therapy – Limited to 1 time per tooth in any 24 consecutive month period.	
D3310	Anterior (excluding final restoration)	<u>86.00 – 570.00</u>
D3320	Bicuspid (excluding final restoration)	<u>105.00 – 630.00</u>
D3330	Molar (excluding final restoration)	<u>135.00 – 855.00</u>
D3331	Treatment or root canal obstruction; non-surgical access	<u>32.00 – 253.00</u>
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	<u>80.00 – 354.00</u>
D3333	Internal root repair or perforation defects	<u>27.00 – 175.00</u>
D3346	Retreatment of previous root canal therapy - anterior	<u>126.00 – 825.00</u>
D3347	Retreatment of previous root canal therapy - bicuspid	<u>150.00 – 885.00</u>
D3348	Retreatment of previous root canal therapy - molar	<u>180.00 – 1,005.00</u>
D3351	Apexification/recalcification - initial visit (apical closure/calific repair of perforations, root resorption, etc.)	<u>52.00 – 142.00</u>
D3352	Apexification/recalcification - interim medication replacement (apical closure/calific repair of perforations, root resorption, etc.)	<u>23.00 – 142.00</u>
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calific repair of perforations, root resorption, etc.)	<u>80.00 – 142.00</u>
D3410	Apicoectomy/periradicular surgery - anterior	<u>107.00 – 705.00</u>
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	<u>117.00 – 778.00</u>
D3425	Apicoectomy/periradicular surgery - molar (first root)	<u>132.00 – 840.00</u>
D3426	Apicoectomy/periradicular surgery (each additional root)	<u>44.00 – 210.00</u>
D3430	Retrograde filling - per root	<u>33.00 – 225.00</u>
D3450	Root amputation - per root	<u>67.00 – 243.00</u>
D3470	Intentional reimplantation (including necessary splinting)	<u>75.00 – 425.00</u>
D3920	Hemisection (including any root removal), not including root canal therapy	<u>52.00 – 270.00</u>

[Type III Dental Services

ADA CODE	DENTAL PROCEDURE	SCHEDULE AMOUNT
	Periodontal Surgery – Only one procedure is covered per area of the mouth, in any <u>36</u> consecutive months.	
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	\$ <u>88.00</u> – \$ <u>480.00</u>
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	<u>27.00</u> – <u>261.00</u>
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	<u>100.00</u> – <u>495.00</u>
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant	<u>61.00</u> – <u>247.00</u>
D4245	Apically positioned flap	<u>73.00</u> – <u>371.00</u>
D4249	Clinical crown lengthening - hard tissue	<u>106.00</u> – <u>690.00</u>
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	<u>151.00</u> – <u>1089.00</u>
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant	<u>89.00</u> – <u>810.00</u>
D4263	Bone replacement graft - first site in quadrant	<u>52.00</u> – <u>405.00</u>
D4264	Bone replacement graft - each additional site in quadrant	<u>26.00</u> – <u>202.00</u>
D4266	Guided tissue regeneration - resorbable barrier, per site	<u>61.00</u> – <u>545.00</u>
D4267	Guided tissue regeneration - nonresorbable barrier, per site (included membrane removal)	<u>80.00</u> – <u>202.00</u>
D4270	Pedicle soft tissue graft procedure	<u>122.00</u> – <u>810.00</u>
D4271	Free soft tissue graft procedure (including donor site surgery)	<u>125.00</u> – <u>810.00</u>
D4273	Subepithelial connective tissue graft procedures, per tooth	<u>132.00</u> – <u>537.00</u>
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	<u>38.00</u> – <u>648.00</u>
D4275	Soft tissue allograft	<u>108.00</u> – <u>607.00</u>
D4276	Combined connective tissue and double pedicle graft, per tooth	<u>163.00</u> – <u>805.00</u>
	Provisional splinting - Limited to 1 time per area of the mouth in any 24 consecutive month period. Benefits include all repairs within that 24 month period.	
D4320	Provisional splinting - intracoronal	<u>59.00</u> – <u>343.00</u>
D4321	Provisional splinting - extracoronal	<u>51.00</u> – <u>344.00</u>
	Periodontal scaling and root planing - Limited to 1 time per quadrant of the mouth in any <u>48</u> consecutive month period.	
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	<u>29.00</u> – <u>170.00</u>
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	<u>16.00</u> – <u>132.00</u>
	Full or Partial Dentures. See items 5 and 7 of EXCLUSIONS.	
D5110	Complete denture - maxillary	<u>171.00</u> – <u>1,110.00</u>
D5120	Complete denture - mandibular	<u>171.00</u> – <u>1,080.00</u>

[Type III Dental Services

ADA CODE	DENTAL PROCEDURE	SCHEDULE AMOUNT
D5130	Immediate denture - maxillary	\$ <u>186.00 – \$ 1,170.00</u>
D5140	Immediate denture - mandibular	<u>186.00 – 1,080.00</u>
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	<u>144.00 – 1,080.00</u>
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	<u>153.00 – 1,080.00</u>
D5213	Maxillary partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth)	<u>187.00 – 1,200.00</u>
D5214	Mandibular partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth)	<u>187.00 – 1,260.00</u>
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	<u>195.00 – 1,080.00</u>
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	<u>195.00 – 1,080.00</u>
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	<u>115.00 – 630.00</u>
D5860	Overdenture, complete, by report	<u>163.00 – 1,110.00</u>
D5861	Overdenture, partial, by report	<u>145.00 – 1,110.00</u>
	Repairs and adjustments to dentures or bridges – Limited to repairs or adjustments done more than <u>24</u> months after the initial insertion.	
D5510	Repair broken complete denture base	<u>20.00 – 144.00</u>
D5520	Replace missing or broken teeth - complete denture (each tooth)	<u>17.00 – 120.00</u>
D5610	Repair resin denture base	<u>22.00 – 165.00</u>
D5620	Repair cast framework	<u>25.00 – 178.00</u>
D5630	Repair or replace broken clasp	<u>29.00 – 150.00</u>
D5640	Replace broken teeth - per tooth	<u>18.00 – 120.00</u>
D5650	Add tooth to existing partial denture	<u>25.00 – 150.00</u>
D5660	Add clasp to existing partial denture	<u>31.00 – 150.00</u>
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	<u>97.00 – 653.00</u>
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	<u>97.00 – 693.00</u>
	Relining or rebasing of Dentures – Limited to relining or rebasing done more than <u>12</u> months after the initial insertion and then not more than 1 time in any 24 consecutive month period.	
D5710	Rebase complete maxillary denture	<u>73.00 – 495.00</u>
D5711	Rebase complete mandibular denture	<u>69.00 – 427.00</u>
D5720	Rebase maxillary partial denture	<u>69.00 – 467.00</u>
D5721	Rebase mandibular partial denture	<u>69.00 – 495.00</u>
D5730	Reline complete maxillary denture (chairside)	<u>40.00 – 240.00</u>
D5731	Reline complete mandibular denture (chairside)	<u>40.00 – 240.00</u>
D5740	Reline maxillary partial denture (chairside)	<u>37.00 – 240.00</u>

[Type III Dental Services

ADA CODE	DENTAL PROCEDURE	SCHEDULE AMOUNT
D5741	Reline mandibular partial denture (chairside)	\$ 37.00 - \$ 240.00
D5750	Reline complete maxillary denture (laboratory)	55.00 – 330.00
D5751	Reline complete mandibular denture (laboratory)	55.00 – 285.00
D5760	Reline maxillary partial denture (laboratory)	55.00 – 311.00
D5761	Reline mandibular partial denture (laboratory)	55.00 – 330.00
D5810	Interim complete denture (maxillary)	88.00 – 555.00
D5811	Interim complete denture (mandibular)	93.00 – 540.00
D5820	Interim partial denture (maxillary)	66.00 – 396.00
D5821	Interim partial denture (mandibular)	69.00 – 435.00
D5850	Tissue conditioning, maxillary	18.00 – 135.00
D5851	Tissue conditioning, mandibular	18.00 – 120.00
	Implant supported prosthetics - See items 5 and 7 of EXCLUSIONS.	
D6053	Implant/abutment supported removable denture for completely edentulous arch	184.00 – 1,110.00
D6054	Implant/abutment supported removable denture for partially edentulous arch	184.00 – 1,110.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	184.00 – 820.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	184.00 – 820.00
D6061	Abutment supported porcelain fused to metal crown (noble metal)	184.00 – 820.00
D6062	Abutment supported cast metal crown (high noble metal)	166.00 – 956.00
D6063	Abutment supported cast metal crown (predominantly base metal)	166.00 – 956.00
D6064	Abutment supported cast metal crown (noble metal)	166.00 – 956.00
D6065	Implant supported porcelain/ceramic crown	168.00 – 1,297.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	168.00 – 1,297.00
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	68.00 - 1,297.00
D6068	Abutment supported retainer for porcelain/ceramic FPD	184.00 – 820.00
D6069	Abutment supported retainer for porcelain/fused to metal FPD (high noble metal)	184.00 – 820.00
D6070	Abutment supported retainer for porcelain/fused to metal FPD (predominantly base metal)	184.00 – 820.00
D6071	Abutment supported retainer for porcelain/fused to metal FPD (noble metal)	184.00 – 820.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	162.00 - 1,046.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	162.00 - 1,046.00

[Type III Dental Services

ADA CODE	DENTAL PROCEDURE	SCHEDULE AMOUNT
D6074	Abutment supported retainer for cast metal FPD (noble metal)	<u>\$162.00 - \$ 1,046.00</u>
D6075	Implant supported retainer for ceramic FPD	<u>168.00 – 1,297.00</u>
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	<u>168.00 – 1,297.00</u>
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	<u>168.00 – 1,297.00</u>
D6078	Implant/abutment supported fixed denture for completely edentulous arch	<u>225.00 – 2,520.00</u>
D6079	Implant/abutment supported fixed denture for partially edentulous arch	<u>225.00 – 2,520.00</u>
D6094	Abutment supported crown - (titanium)	<u>166.00 – 956.00</u>
D6194	Implant supported retainer crown for FPD - (titanium)	<u>168.00 – 1,297.00</u>
	Placement of Fixed Bridgework – See items 5 and 7 of EXCLUSIONS.	
D6205	Pontic -indirect resin based composite	<u>130.00 – 324.00</u>
D6210	Pontic - cast high noble metal	<u>130.00 – 680.00</u>
D6211	Pontic - cast predominantly base metal	<u>122.00 – 919.00</u>
D6212	Pontic - cast noble metal	<u>126.00 – 717.00</u>
D6214	Pontic - titanium	<u>136.00 – 765.00</u>
D6240	Pontic - porcelain fused to high noble metal	<u>129.00 – 717.00</u>
D6241	Pontic - porcelain fused to predominantly base metal	<u>119.00 – 810.00</u>
D6242	Pontic - porcelain fused to noble metal	<u>126.00 – 597.00</u>
D6245	Pontic - porcelain/ceramic	<u>148.00 – 623.00</u>
D6250	Pontic - resin with high noble metal	<u>148.00 – 623.00</u>
D6251	Pontic - resin with predominantly base metal	<u>148.00 – 623.00</u>
D6252	Pontic - resin with noble metal	<u>148.00 – 623.00</u>
D6253	Provisional pontic	<u>44.00 – 352.00</u>
D6545	Retainer - cast metal for resin bonded fixed prosthesis	<u>55.00 – 460.00</u>
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	<u>77.00 – 496.00</u>
D6600	Inlay - porcelain/ceramic, two surfaces	<u>115.00 – 810.00</u>
D6601	Inlay - porcelain/ceramic, three or more surfaces	<u>131.00 – 645.00</u>
D6602	Inlay - cast high noble metal, two surfaces	<u>105.00 – 660.00</u>
D6603	Inlay - cast high noble metal, three or more surfaces	<u>120.00 – 766.00</u>
D6604	Inlay - cast predominantly base metal, two surfaces	<u>105.00 – 561.00</u>
D6605	Inlay - cast predominantly base metal, three or more surfaces	<u>120.00 – 650.00</u>
D6606	Inlay - cast noble metal, two surfaces	<u>105.00 – 594.00</u>
D6607	Inlay - cast noble metal, three or more surfaces	<u>120.00 – 689.00</u>
D6608	Onlay - porcelain/ceramic, two surfaces	<u>121.00 – 810.00</u>
D6609	Onlay - porcelain/ceramic, three or more surfaces	<u>128.00 – 810.00</u>
D6610	Onlay - cast high noble metal, two surfaces	<u>118.00 – 720.00</u>
D6611	Onlay - cast high noble metal, three or more surfaces	<u>129.00 – 750.00</u>
D6612	Onlay - cast predominantly base metal, two surfaces	<u>118.00 – 612.00</u>
D6613	Onlay - cast predominantly base metal, three or more surfaces	<u>129.00 – 688.00]</u>

[Type III Dental Services

ADA CODE	DENTAL PROCEDURE	SCHEDULE AMOUNT
D6614	Onlay - cast noble metal, two surfaces	\$ <u>118.00 – 648.00</u>
D6615	Onlay - cast noble metal, three or more surfaces	<u>129.00 – 675.00</u>
D6624	Inlay - titanium	<u>139.00 – 765.00</u>
D6634	Onlay - titanium	<u>134.00 – 765.00</u>
D6710	Crown - indirect resin based composite	<u>129.00 – 324.00</u>
D6720	Crown - resin with high noble metal	<u>51.00 – 623.00</u>
D6721	Crown - resin with predominantly base metal	<u>51.00 – 623.00</u>
D6722	Crown - resin with noble metal	<u>51.00 – 623.00</u>
D6740	Crown - porcelain/ceramic	<u>136.00 – 717.00</u>
D6750	Crown - porcelain fused to high noble metal	<u>136.00 – 717.00</u>
D6751	Crown - porcelain fused to predominantly base metal	<u>129.00 – 919.00</u>
D6752	Crown - porcelain fused to noble metal	<u>131.00 – 600.00</u>
D6780	Crown - 3/4 cast high noble metal	<u>133.00 – 680.00</u>
D6781	Crown - 3/4 cast predominantly base metal	<u>126.00 – 810.00</u>
D6782	Crown - 3/4 cast noble metal	<u>128.00 – 656.00</u>
D6783	Crown - 3/4 porcelain/ceramic	<u>135.00 – 900.00</u>
D6790	Crown - full cast high noble metal	<u>132.00 – 765.00</u>
D6791	Crown - full cast predominantly base metal	<u>125.00 – 919.00</u>
D6792	Crown - full cast noble metal	<u>128.00 – 717.00</u>
D6793	Provisional retainer crown	<u>43.00 – 352.00</u>
D6794	Crown - titanium	<u>137.00 – 765.00</u>
D6970	Cast post and core in addition to fixed partial denture retainer	<u>51.00 – 325.00</u>
D6972	Prefabricated post and core in addition to fixed partial denture retainer	<u>39.00 – 177.00</u>
D6973	Core build up for retainer, including any pins	<u>31.00 – 180.00</u>
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	<u>30.00 – 195.00</u>
D7220	Removal of impacted tooth - soft tissue	<u>37.00 – 243.00</u>
D7230	Removal of impacted tooth - partially bony	<u>50.00 – 270.00</u>
D7240	Removal of impacted tooth - completely bony	<u>59.00 – 330.00</u>
D7241	Removal of impacted tooth - completely bony with unusual surgical complications	<u>78.00 – 433.00</u>
D7250	Surgical removal of residual tooth roots (cutting procedure)	<u>34.00 – 180.00</u>
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	<u>75.00 – 425.00</u>
D7280	Surgical access of an unerupted tooth	<u>75.00 – 425.00</u>
D7285	Biopsy of oral tissue - hard (bone, tooth)	<u>131.00 – 283.00</u>
D7286	Biopsy of oral tissue - soft	<u>56.00 – 270.00</u>
D7287	Exfoliative cytological sample collection	<u>16.00 – 202.00</u>
D7288	Brush biopsy - transepithelial sample collection	<u>15.00 – 101.00</u>
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	<u>16.00 – 85.00</u>

[Type III Dental Services

ADA CODE	DENTAL PROCEDURE	SCHEDULE AMOUNT
D7310	Alveoloplasty in conjunction with extractions - per quadrant	<u>\$ 38.00 – \$ 180.00</u>
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces per quadrant	<u>25.00 – 90.00</u>
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	<u>72.00 – 766.00</u>
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces per quadrant	<u>47.00 – 383.00</u>
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	<u>77.00 – 544.00</u>
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	<u>155.00 – 1,089.00</u>
D7410	Excision of benign lesion up to 1.25 cm	<u>57.00 – 243.00</u>
D7411	Excision of benign lesion greater than 1.25 cm	<u>57.00 – 243.00</u>
D7412	Excision of benign lesion, complicated	<u>57.00 – 243.00</u>
D7413	Excision of malignant lesion up to 1.25 cm	<u>57.00 – 243.00</u>
D7414	Excision of malignant lesion greater than 1.25 cm	<u>57.00 – 243.00</u>
D7415	Excision of malignant lesion, complicated	<u>57.00 – 243.00</u>
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	<u>57.00 – 243.00</u>
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm	<u>57.00 – 243.00</u>
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	<u>57.00 – 243.00</u>
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	<u>57.00 – 243.00</u>
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	<u>57.00 – 243.00</u>
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	<u>57.00 – 243.00</u>
D7465	Destruction of lesion(s) by physical or chemical method, by report	<u>57.00 – 243.00</u>
D7471	Removal of lateral exostosis (maxilla or mandible)	<u>121.00 – 659.00</u>
D7472	Removal of torus palatinus	<u>135.00 – 877.00</u>
D7473	Removal of torus mandibularis	<u>102.00 – 659.00</u>
D7485	Surgical reduction of osseous tuberosity	<u>102.00 – 659.00</u>
D7510	Incision and drainage of abcess - intraoral soft tissue	<u>21.00 – 180.00</u>
D7511	Incision and drainage of abcess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	<u>36.00 – 360.00</u>
D7520	Incision and drainage of abcess - extraoral soft tissue	<u>59.00 – 360.00</u>
D7521	Incision and drainage of abcess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	<u>117.00 – 720.00</u>
D7951	Sinus augmentation with bone or bone substitutes	<u>52.00 – 675.00</u>

[Type III Dental Services

ADA CODE	DENTAL PROCEDURE	SCHEDULE AMOUNT
D7963	Frenuloplasty	<u>\$ 78.00 – \$ 653.00</u>
D7970	Excision of hyperplastic tissue - per arch	<u>81.00 – 544.00</u>
D7971	Excision of pericoronal gingiva	<u>30.00 – 198.00</u>
D7972	Surgical reduction of fibrous tuberosity	<u>54.00 – 648.00</u>
	General Anesthesia – [Will be paid for as a separate procedure only when required for extraction of impacted teeth, if such extraction is a Covered Expense.]	
9220	General Anesthesia	<u>52.00 – 254.00</u>
9221	General Anesthesia/ Additional 15 minutes	<u>23.00 – 180.00]</u>

PART 6: DENTAL EXPENSE BENEFITS: EXCLUSIONS

[COVERED DENTAL EXPENSES do not include and no benefits are provided for:

1. Procedures which are not included in the list of COVERED DENTAL EXPENSES.
2. Procedures which we determine to be unnecessary.
3. Procedures which we determine do not have uniform professional endorsement.
4. Procedures related to the change of vertical dimension, restoration of occlusion, bite registration, or bite analysis.
5. Charges for replacement of bridges, partial or full dentures, inlays, onlays, crowns, implant crowns and other laboratory prepared restorations:
 - a) if they can, as determined by us, be satisfactorily repaired and restored to function; or
 - [[b) if within 120 consecutive months of the date of insertion.]]
 - [[b) until 120 consecutive months of the date of insertion and a Covered Person has been insured under the policy for at least 36 consecutive months.

Exceptions to exclusion 5b will be made if the replacement is made necessary by:

 - i) the extraction of a Functioning Natural Tooth. Such extraction must be performed by a Dentist while the Covered Person is insured under the policy; or
 - ii) Accidental Bodily Injury. Such Injury must occur while the Covered Person is insured under the policy. Chewing Injuries are not considered Accidental Bodily Injuries.]]
6. [[Implants,]] lost or stolen appliances, precision or semi-precision attachments, over dentures or customized prostheses, denture duplication, or other customized attachments.
7. The initial placement of:
 - a) [[Implants or]] partial or full dentures, if the prosthesis includes only the replacement of teeth missing prior to the effective date of the Covered Person's coverage including congenitally missing teeth; or
 - b) Bridges, if the prosthesis includes the replacement of teeth missing:
 - i) prior to the effective date of the Covered Person's coverage, including congenitally missing teeth; or
 - ii) that are not adjacent to a Functioning Natural Tooth that is extracted by a Dentist while the Covered Person is insured under the policy; or
 - c) Implant crowns, if the prosthesis includes the replacement of teeth missing prior to the effective date of the Covered Person's coverage, including congenitally missing teeth.
8. Procedures that we determine are cosmetic in nature.]

9. [Charges for any of the following:
- a) dental care arising out of or in the course of employment for pay or profit or which is covered by Workers' Compensation or a similar law;
 - b) care, treatment, services or supplies which are furnished, paid for or reimbursable by any government or subdivision of government. This restriction will not apply:
 - i) to the extent that the Covered Person is required by law to pay such charges;
 - ii) to charges incurred by a veteran for non-service connected COVERED DENTAL EXPENSES;
 - iii) to charges incurred by retired veterans or Dependents of veterans confined in a military hospital;
 - c) dental care resulting from any injury sustained as a result of war, declared or undeclared, or any action of war or any resistance to armed invasion or aggression or international police action;
 - d) failure to keep appointments;
 - e) dental care resulting from any injury which is self-inflicted or not caused by an accident;
 - f) dental care resulting from active participation in a riot;

The words "participation" and "riot" in the phrase "participation in a riot" will be defined as follows:

Participation - includes promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but will not include actions taken in defense of public or private property, or actions taken in defense of the person of the insured, if such actions of defense are not taken against persons seeking to maintain or restore law and order including but not limited to police officers and firemen.

Riot - includes all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together whether or not acting with common intent and whether or not damage to person or property or unlawful act or acts is the intent or the consequences of such disorder; and

- g) dental care resulting from participation in the commission of a felony.
10. Charges for crown or core buildups and pulp caps.
11. Charges for sedative fillings except as shown in the list of COVERED DENTAL EXPENSES.
12. Charges for orthognathic surgery or any other procedure, service or supply required directly or indirectly to treat a muscular, skeletal, orthopedic, or neural disorder, dysfunction or disease of the temporomandibular joint and its associated structures including myofascial pain dysfunction syndrome but not limited to:
- a) orthodontics such as braces;
 - b) prosthodontics such as:
 - i) crowns; or
 - ii) bridgework;
 - c) periodontics and related procedures;
 - d) endodontics;
 - e) occlusal adjustments; and
 - f) surgical procedures required for the placement of:
 - i) dentures; or
 - ii) other prosthetic devices.]

13. [Charges made by a Dentist or Dental Hygienist who:
 - a) normally lives in the Covered Person's home; or
 - b) is a member of your immediate family.
Immediate family is limited to:
 - i) you;
 - ii) your spouse [[or Domestic Partner;]] and
 - iii) parents, brothers, sisters or children of either you or your spouse [[or Domestic Partner]], whether related by blood or marriage.
14. COVERED DENTAL EXPENSES incurred while insurance is not in force.
15. Charges for care, treatment, services, or supplies to the extent that any benefit is provided by Medicare.
16. Charges which are not customarily made when there is no insurance, or charges for which there is no legal obligation to pay.
17. Dental care which is not customarily performed or which is experimental in nature, or for implantology.
18. Charges for oral hygiene instruction, a plaque control program or dietary instruction.
19. Orthodontic Treatment [[for Covered Persons age 19 and older.]]
20. Charges for sealants.]

PART 7: DENTAL EXPENSE BENEFITS: COORDINATION OF BENEFITS

Definitions

Plan

Any plan provided by any employer or any other plan required by law that provides dental expense benefits or services under:

1. Group insurance or any other insured or uninsured arrangement of coverage (excluding any individual insurance) for which any employer:
 - a) contributes all or part of the cost; or
 - b) makes payroll deductions; or
2. Basic automobile reparations (no-fault) insurance, but only:
 - a) to the extent of the benefits required by or available under the applicable no-fault law; and
 - b) if such no-fault insurance does not, under its rules, determine its benefits after the benefits of any group health insurance.

The term "Plan" will be construed as follows:

1. Separately with respect to each policy, contract, or other arrangement for benefits or services; and
2. Separately with respect to each of the following:
 - a) that part of any such policy, contract, or other arrangement which reserves the right to take into account the benefits or services of other Plans in determining benefits; and
 - b) that part which does not reserve such right.

Benefits payable under another Plan include the benefits that would have been payable if claim had been made for them.

This Plan

Your Employer's Plan of DENTAL EXPENSE BENEFITS with us.

Allowable Expense

Any necessary, reasonable, and customary item of COVERED DENTAL EXPENSE (as defined in Parts 5 and 6) that is at least partly covered under at least one of the Plans covering the person for whom claim is made.

When a Plan provides benefits in the form of services rather than cash, the value of each service rendered will be considered to be both:

1. An Allowable Expense; and
2. A benefit paid.

Claim Determination Period

A Calendar Year. However, if a person is not eligible for benefits under This Plan during all of a Calendar Year, the Claim Determination Period for the person for that Year will be the part of the Year during which he or she was eligible for benefits.

COB

Coordination of Benefits.

Use of COB

In computing the benefits payable under This Plan, the benefits from other Plans will be taken into account. This may require a reduction in benefits under This Plan, so that the combined benefits will not be more than the Allowable Expenses of This Plan and any other Plan.

Computation of Benefits under COB

Specifically, in a Calendar Year, This Plan will always either pay its regular benefits in full, or it will pay a reduced amount which, when added to the benefits payable and the cash value of any services provided by the other Plans, will equal 100% of the Allowable Expenses incurred by the person for whom claim is being made.

Limit on Use of COB

In computing the benefits under This Plan, the benefits under any other Plan will not be included if:

1. Such other Plan contains a COB provision that:
 - a) provides for coordinating its benefits with those of This Plan; and
 - b) under its terms, would compute its benefits after we compute the benefits under This Plan; and
2. The rules shown in the "Order of Benefit Determination" section require that This Plan's benefits are computed before such other Plan computes its benefits.

Order of Benefit Determination

To administer this provision properly, and to determine whether we will reduce the benefit we would have paid if COB had not been included, it is necessary to determine the order in which the various Plans will pay benefits. This will be determined as follows:

1. A Plan with no COB provision will be considered to pay its benefits before a Plan that contains such a provision.
2. A Plan that covers a person other than as a dependent will be considered to pay its benefits before a Plan that covers that person as a dependent.
- [[3. A Plan that covers a person as a dependent of an employee whose month and day of birth occur earlier in the calendar year will be considered to pay its benefits before a Plan that covers that person as a dependent of an employee whose month and day of birth occur later in the calendar year. If, however, the COB provisions of any other Plan do not contain a rule like the one described in the preceding sentence, then such rule will not apply and the applicable rule set forth in such other Plan shall determine the order of benefit payment. However, if the parents of a dependent child are separated or divorced the following rules apply:
 - a) if there is a court decree that sets responsibility for the child's health care, a Plan that covers the child as a dependent of the parent with such responsibility will be considered to pay its benefits before any other Plan that covers the child as a dependent child; otherwise
 - b) if the parent with custody of the child has not remarried, a Plan that covers the child as a dependent of that parent will be considered to pay its benefits before a Plan that covers the child as a dependent of the parent without custody.
 - c) if the parent with custody of the child has remarried:
 - i) a Plan that covers the child as a dependent of that parent will be considered to pay its benefits before a Plan that covers that child as a dependent of the step-parent; and
 - ii) a Plan that covers such child as a dependent of the step-parent will be considered to pay its benefits before a Plan that covers the child as a dependent of the parent without custody.]]
4. Where 1, 2, and 3 above do not establish the order of payment, the Plan under which the person has been covered for the longer period of time will be considered to pay its benefits before the other. However:
 - a) a Plan that covers a person as a laid-off or retired employee, or as a dependent of such a person, will be considered to pay its benefits after a Plan that covers such person as other than a laid-off or retired employee, or as a dependent of such a person.
 - b) if the other Plan does not contain a rule like the one described above in item 4-a, then such rule shall not apply.

Our Rights Under COB

We have the right to release or obtain any information and make or recover any payments we consider necessary in order to administer this provision.

Right To Receive or Release Necessary Information

We may, without the consent of or notice to any person, release to or obtain from any other insurance company, organization or person, any information, with respect to any person, that may be needed to apply the terms of the COB provision or any similar provision of any other Plan.

Any person who claims benefits under This Plan must furnish to us any information that we may need to apply the COB provision. For the purposes of this section only, any person who is insured under This Plan will be deemed to have authorized us to secure the information necessary to apply the terms of this provision.

Facility of Payment

If any payment that should have been made under This Plan according to the COB provision is made under any other Plan, we have the right to pay to the organization that made such payment any amount that, in our judgement, will satisfy the intent of the COB provision. Any amount so paid will:

1. Be deemed a benefit paid under This Plan; and
2. Fully discharge us from our liability under This Plan.

Right of Recovery

If a payment made under This Plan is in excess of the total amount required to satisfy the intent of the COB provision, we have the right to recover any excess amount from one or more of the following:

1. Any person to whom, for whom, or with respect to whom such payment is made.
2. Any other insurance company.
3. Any other organization.

PART 8: TERMINATION PROVISIONS

[Termination of Employee [[and Dependent]] Insurance

The DENTAL EXPENSE BENEFITS coverage for you [[and your Dependents]] will automatically cease on the earliest date shown below:

1. On the last day of the calendar month in which you are no longer Actively At Work except that:
 - a) while you are sick or injured, your employment will be deemed to continue, for up to 12 months from the date your disability began as long as your Employer keeps paying premiums on your behalf;
 - b) while you are temporarily laid off or on a temporary leave of absence, your employment will be deemed to continue, as long as premium payments are made, for up to two months, unless your Employer cancels your insurance before the end of that time;
 - c) while you are on an approved leave of absence granted in accordance with a State Family Leave Law or the Federal Family and Medical Leave Act (FMLA), your coverage will be deemed to continue, provided premium payments are made and the continuation of coverage during this leave is based upon a uniform policy of your Employer and not individual selection, for the lesser of the duration of the approved leave or 4 months from the last day you are Actively At Work, unless your Employer cancels your insurance before the end of that time;
 - d) while you are on a leave of absence due to your military service in any of the Uniformed Services of the United States, your employment will be deemed to continue as outlined in either item 1-b or 1-c above, as applicable, as long as premium payments are made, unless your Employer cancels your insurance before the end of that time. For additional information on how you can continue your coverage, see the **Uniformed Services Employment and Re-employment Rights Act of 1994** part.

[[e) when you become a Retired Employee, your Dental Expense Benefits coverage will be deemed to continue as long as your Employer keeps paying premiums on your behalf;]]
2. On the last day of the calendar month in which you cease to be in a class of Employees who are eligible for such coverage;
3. On the date you fail to make any required contribution;
4. On the date such coverage is terminated for any reason;
5. On the date such coverage is terminated for the class of Employees to which you belong;
- [[6. On the date the policy terminates.]]
- [[6. On the date your Employer's participation in the Trust and under the policy is terminated.]]
7. On the date you become covered under an alternate plan of dental benefits made available by your Employer.]

[[Termination of Dependent Coverage Only

The DENTAL EXPENSE BENEFITS coverage for your Dependents only will automatically cease before your Employee Insurance on the earliest of:

1. The date you cease to be in a class of Employees who are eligible for such Dependent Coverage.
2. The date you fail to make any required contribution for such Dependent Coverage.
3. The date such Dependent Coverage is terminated for any reason.
4. The date a person ceases to be a Dependent as defined in the policy, but only with respect to such person.
5. [[The date of the termination of a Domestic Partner relationship, as evidenced by a signed Declaration of Termination of Domestic Partnership.]]]]

PART 8A: Uniformed Services Employment and Re-employment Rights Act of 1994

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) provides that your Employer must allow you to elect to continue dental coverage for yourself and your Dependents as follows:

1. Unless unforeseen circumstances prevent it, you or your Dependent must provide notification to your Employer of your pending Uniformed Service;
2. The maximum period of coverage for you and any covered Dependent(s) shall be the lesser of:
 - a) The twenty-four (24) month period beginning on the date on which your absence begins; or
 - b) The day after the date on which you were required to apply for or return to a position of employment but failed to do so.
3. If you elect to continue coverage under the Plan, you may be required to pay up to one hundred and two percent (102%) of the full cost of the coverage under the Plan, except an individual person on active duty for thirty (30) calendar days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
4. You must elect coverage for yourself in order for your Dependents to be covered under this continuance provision. Dependents do not have an independent right to make an election.
5. The 24-month continuance benefit period required under USERRA shall run concurrently with any continuation of benefits elected under COBRA or a state continuance if required by law.

If you apply for re-employment within the time limit specified under the USERRA, you will have coverage under the Plan reinstated for yourself and your Dependent(s) provided you request reinstatement of coverage within 31 days of your return to active employment. No Waiting Period or limitations will apply in connection with the reinstatement of coverage under the Plan upon re-employment if one would not have been imposed had coverage not been terminated because of service.

PART 9: GENERAL PROVISIONS

The Policy and Application

The group policy issued to the Policyholder, together with the application of the Policyholder, is the entire contract between us and the Policyholder. All statements that the Policyholder, [[the Employer,]] or you, the [Employee], make are deemed to be representations and not warranties. No written statement signed by you will be used in any legal action against you unless we give you or your representative a copy.

Changes To The Policy

We and the Policyholder can change the policy in its entirety or with respect to any or all class or classes of [Employees] [[of any Employer]] at any time if we and the Policyholder agree in writing to make such a change. Any such change will be valid without the consent of any person other than the Policyholder and us. All such changes will be signed by our President, Vice President, Secretary or Treasurer and countersigned by one of our registrars or our President, Vice President, Secretary or Treasurer. No agent may change or waive any of the policy provisions; nor can an agent make any agreement that would be binding on us.

Waiver of Policy Provision

If at some time we choose to waive a policy provision, we still retain our right to enforce that provision at any other time. To be effective, such waiver must be in writing and signed by a person who is authorized by us to waive such terms.

Limit of Premium Refunds

Whether premiums were paid in error or otherwise, we will refund only that part of the excess premium that was paid during the 12-month period that preceded the date we learned of such overpayment.

Clerical Error

Clerical errors in connection with the policy or delays in keeping records for the policy whether by us[, the Policyholder,]] or the [Employer]:

1. Will not terminate insurance that would otherwise have been effective.
2. Will not continue insurance that would otherwise have ceased or should not have been in effect.

If appropriate, a fair adjustment of premium will be made to correct the error, subject to the "Limit of Premium Refunds" section.

Misstatement of Facts

If relevant facts about the [Employer] or [Employee] relating to this insurance are not accurate:

1. If appropriate, a fair adjustment of premium will be made, subject to the "Limit of Premium Refunds" section.
2. The true facts will decide whether, and in what amount, and for what duration insurance is valid under the policy.

Notice

Any obligation we may have to give written notice will be satisfied by sending such notice to the last known address of the person or institution entitled to such notice.

Discharge of Our Responsibility

Payment made under the terms of any section of the policy will, to the extent of such payment, release us from all further obligations under the policy. We will not be obligated to see to the application of such payment.

Reimbursement

Reimbursement will be made to us for any overpayments that we may make due to any reason. Deductions may be made from future benefit payments to recover any such overpayments.

If we have reimbursed you for all or part of a payment which you [[or a Covered Dependent, if any,]] were entitled to recover from a third party, you [[or such Dependent]] must repay us at that time to the extent that we have reimbursed you [[or such Dependent]], regardless of whether your coverage [[or that of such Dependent]] is still in force on the date you [[or such Dependent]] recover such amount.

PART 10: GENERAL DENTAL PROVISIONS

Proofs of Claim

Proof of claim must be sent to us in writing within 90 days of the Incurred Date of the dental treatment. If such Proof cannot be sent within this time limit, it must be sent as soon as reasonably possible, but not later than 12 months of the Incurred Date.

Such Proofs of claim must be made on the forms we require. If such forms are not available due to our failure to furnish them upon request of the Policyholder [[or Employer]], your compliance with the remaining terms of this section will satisfy your responsibility to us regarding Proofs of claim.

You [[and all persons covered under the policy]] are required to furnish any information that we may reasonably require to review your Proof of claim. If you [[or other Covered Persons]] fail to furnish information we require to verify the eligibility or insurability of you [[or other Covered Persons]], we reserve the right to terminate or rescind such coverage. Also, we have the right to require any of the following:

1. A complete dental chart showing:
 - a) extractions;
 - b) missing teeth;
 - c) fillings;
 - d) prostheses;
 - e) periodontal pocket depths; and
 - f) the date of any work previously performed.
2. An itemized bill for all dental care.
3. The following exhibits:
 - a) x-rays;
 - b) study models;
 - c) laboratory and/or hospital records.
4. A dental examination at our expense by a Dentist whom we choose.
- [[5. Completion of a brief questionnaire which will specify:
 - a) the degree of overjet, overbite, crowding, open bite;
 - b) if teeth are impacted in crossbite, or congenitally missing;
 - c) the length of treatment; and
 - d) the total charge for the treatment.]]
 6. Any additional information we may need to process your claim. If you [[or other covered persons]] fail to furnish information we require to verify [the eligibility of you] [[or other covered persons]], we reserve the right to terminate or rescind such coverage.

If you [[or any other covered person]] commits an act of fraud in attempting to secure benefits from us, we may terminate or rescind your [[(and your Dependents)]] coverage [[or the coverage of the person who commits such act]].

If we rescind coverage, we will refund any premium paid less any claim reimbursements.

Physical Examination

Except as otherwise provided in the policy, we have the right to have you [[or your Dependent]] examined as often as is reasonably necessary following the receipt of a claim and while a claim is pending, or while any payments are being made under the policy. Approval of claim for benefits and the continuation of benefits are subject to your [[or your Dependent's]] cooperation in submitting to such examination.

Legal Actions

For 60 days after written Proof of claim, as required by us, has been filed, no legal or equitable action may be brought against us for that claim. No action at all may be brought against us after 3 years from the date on which written Proof of claim is required.

Assignment

You cannot assign any interest in the policy unless we agree in writing to such an assignment. We have the right to determine the extent to which any assignment will be honored and the priority of such assignment. We do not assume any responsibility for the validity or sufficiency of any assignment. Any payments made under such assignment after consented to by us will discharge our liabilities under the policy, to the extent of such payments.

Workers' Compensation

This insurance does not take the place of or affect any requirement for coverage by Workers' Compensation Insurance.

Non-Discrimination

In the administration of the plan, the Policyholder [[and the Employer]] are obligated to treat you and other [Employees] in like situations fairly.

Facility of Payment

We will pay you all benefits, if your Proof of claim is satisfactory to us, except in the following situations:

1. You are a minor. In such case, claim may be made by your duly appointed guardian, conservator or committee and we will pay to such person or persons; or
2. Due to physical or mental incapacity, you cannot, in our judgment, give us a valid receipt for payments. In such case, claim may be made as described in item 1; or
- [[3. Payment made by us pursuant to a qualified medical child support order or other similar court decree in reimbursement for Covered Expenses paid by a child or such child's legal guardian may be made to such child or such child's custodial parent or legal guardian; or]]
4. You die before we pay you. In such case, claim may be made by your executor or the administrator of your estate and we will pay to such person or persons.

If we do not pay you and claim is not made by the appropriate person designated above, we may, at our option, make payments under either or both Methods A or B below. Any decision to pay any benefits, prior to the appointment of the appropriate person designated in items [1, 2, 3 or 4 above], is solely at our discretion, and we may choose to pay no amounts under any circumstances until such appropriate person is formally appointed.

Method A: We may pay the whole or any part of such benefit to any institution or person on whose charges payment of the benefit is based toward the satisfaction of those charges.

Method B: We may pay the whole or any part of such benefit:

- a) to your lawful spouse, up to a cumulative amount of \$1,500; or
- b) if you have no lawful spouse, up to a cumulative amount of \$750 to any one or more of the following relatives in the following order of priority:
 - i) your child or children; or
 - ii) your mother or father.

Time Periods

All time periods referred to in the policy will begin and end at 12:01 A.M. standard time at the [Employer's] home office.

[[DENTAL TAKEOVER PROVISIONS

Definitions:

For the purposes of this part only, the following definitions will apply:

This Plan

Your Employer's group plan of Dental Expense Benefits with us.

Prior Plan

Your Employer's group plan of Dental Expense Benefits that was in force on the day before the effective date of This Plan.

Course Of Treatment

A planned program of one or more services for the treatment of a diagnosed dental condition.

Takeover Provisions:

Applicability

The provisions of this part apply only to a Covered Person who meets both of the following conditions:

1. On the day before the effective date of This Plan, such Covered Person is covered under the Prior Plan on a premium-paying basis; and
2. On the effective date of This Plan, such Covered Person is eligible for coverage.

[[Exception to Maximum Carryover Provision

For the Calendar Year in which This Plan become effective, we will credit a Covered Person's Carryover Account under This Plan with the unused amount contained in a similar Carryover Account of the Prior Plan, if applicable.]]

Exception To Deductible [[and Maximum Benefit]] Provision[[s]]

For the Calendar Year in which This Plan becomes effective, we will reduce a Covered Person's Deductible [[and Maximum Benefit]] under This Plan by any amount of Covered Dental Expenses that are:

1. Incurred in the Calendar Year in which This Plan becomes effective and applied toward the Prior Plan's deductible [[and maximum benefit]] for such year; [[and
2. Incurred in the last three months of the Calendar Year prior to the Calendar Year in which This Plan becomes effective, provided that such Covered Dental Expenses are applied toward the Prior Plan's deductible [[and maximum benefit]] as follows:
 - a) for the Calendar Year prior to the Calendar Year in which This Plan becomes effective; and
 - b) for the Calendar Year in which This Plan becomes effective.]]

[[A Covered Person's Deductible under This Plan cannot be reduced unless we receive the deductible and maximum benefit information of the Prior Plan and subtract any reductions made to the Prior Plan's maximum benefit to the Maximum Benefit of This Plan.]]

Treatment Prior To Effective Date Of This Plan

1. If a Covered Person incurs Covered Dental Expenses for a Course of Treatment that is started before the effective date of This Plan and is finished after such date, benefits for such Covered Person will be payable under the terms of This Plan except that:
 - a) No benefits will be payable for any expenses that are payable under the Prior Plan's extension of benefits provision; and
 - b) Benefits will be payable for only those Covered Dental Expenses incurred during that portion of the Course of Treatment that the Covered Person received while he/she was insured under This Plan.
2. The Maximum Benefit and any other limits on amounts or time limitations on benefits payable under the DENTAL EXPENSE BENEFITS of This Plan shall be reduced by any corresponding amounts or limitations previously paid or satisfied, whether in whole or in part, under the terms of the Prior Plan.

[[Reduction To Lifetime Maximum Benefit

The Lifetime Maximum Benefit payable under This Plan for any Covered Person who incurs Type IV Covered Dental Expenses under the Prior Plan will be reduced by the amount of any benefits paid and/or payable under the Prior Plan.]]

[[Reduction To Calendar Year Maximum Benefit

For the Calendar Year in which This Plan becomes effective, we will reduce a Covered Person's Calendar Year Maximum Benefit under This Plan by any amount of Covered Dental Expenses that are incurred in the Calendar Year in which This Plan becomes effective and applied toward the Prior Plan's Calendar Year Maximum Benefit for such year.]]

[[Exception To Exclusion Provision

Benefits will be payable for Covered Dental Expenses for implants, implant crowns, bridges, or partial or full dentures, to replace a tooth that was extracted while the Covered Person was covered under the Prior Plan. [[Such extraction must have occurred within the preceding 12 months.]] No benefits will be payable for any expenses that are payable under the Prior Plan's extension of benefits provision.]]]]

[[Right To Receive Necessary Information

We may, without the consent of or without notice to any person, obtain from any other insurance company, organization, or person any information, with respect to any person, that may be needed to apply the terms of this provision.

Any person who claims benefits under This Plan under the terms of this part must furnish to us any information which we may need in order to apply these provisions.]]

SUN LIFE ASSURANCE COMPANY OF CANADA certifies that it has issued and delivered a Certificate Amendment to

POLICYHOLDER: THE POLICYHOLDER NAMED ON THE FACE PAGE OF THE GROUP CERTIFICATE

EFFECTIVE DATE: JANUARY 1, 2007

AMENDING GROUP POLICY NO.: THE POLICY NUMBER SHOWN ON THE FACE PAGE OF THE GROUP CERTIFICATE AND THAT IS APPLICABLE TO DENTAL INSURANCE

This Certificate Amendment forms a part of your Group Certificate which describes the provisions of the group policy specified above.

[The Certificate is changed as follows:

1. The name of the Policyholder as set forth on the Policy cover page is changed to read:
Policyholder: <new name>
2. Notice is hereby acknowledged by Sun Life Assurance Company of Canada that all right, title and interest of <old name> in and to the group policy has been assigned to <new name>.
3. It is hereby agreed that said <new name>> will assume the rights and obligations of said <old name> under the policy and that the policy will continue in full force and effect.]

Nothing contained in this Certificate Amendment will be held to affect any of the terms of the Group Certificate other than as stated herein.

This Certificate Amendment is part of the Group Certificate. It should be kept with your Group Certificate which contains the principal provisions of the group policy.

[*Donald A. Stewart.*]

[Chief Executive Officer]

GROUP CERTIFICATE AMENDMENT: _____

SUN LIFE ASSURANCE COMPANY OF CANADA certifies that it has issued and delivered a Certificate Amendment to

POLICYHOLDER: THE POLICYHOLDER NAMED ON THE FACE PAGE OF THE GROUP CERTIFICATE

EFFECTIVE DATE: JANUARY 1, 2007

AMENDING GROUP POLICY NO.: THE POLICY NUMBER SHOWN ON THE FACE PAGE OF THE GROUP CERTIFICATE AND THAT IS APPLICABLE TO DENTAL INSURANCE

This Certificate Amendment forms a part of your Group Certificate which describes the provisions of the group policy specified above.

The Certificate is changed by the addition of the following benefits:

[[Benefits for bleaching of teeth for Covered Persons who are age 19 and over. Benefits will be payable at [[the lesser of the Usual or Customary Charge or the Schedule Amount of \$10 at]] [[the coinsurance percentage shown in the Insurance Schedule for Type III Covered Expenses]]. Benefits will be payable without application of the Per Person Deductible and are subject to a maximum of \$10 in a Calendar Year. Benefits are available only for bleaching performed by a Dentist or Dental Hygienist and for take-home bleaching supplies only when dispensed by a Dentist or Dental Hygienist.]]

[[Benefits for bleaching of teeth and for [veneers, which we determine are cosmetic in nature. Benefits are limited to Covered Persons who are age 19 and over. Benefits will be payable at [[the lesser of the Usual or Customary Charge or the Schedule Amount of \$20 at]] [[the coinsurance percentage shown in the Insurance Schedule for Type III Covered Expenses]]. Benefits will be payable without application of the Per Person Deductible and are subject to a combined maximum of \$50 in a Calendar Year. Benefits for bleaching of teeth are available only for bleaching performed by a Dentist or Dental Hygienist and for take-home bleaching supplies only when dispensed by a Dentist or Dental Hygienist. Benefits for veneers are limited to 1 time per tooth in any 60 consecutive month period.]]

[[If a Covered Person is subject to the Limitation on Late Entrants provision, the benefits provided by this amendment will not be payable until the Covered Person has been insured for 24 months.]]

[[If the Certificate contains a provision entitled "When Coverage Starts", the benefits provided by this amendment will not be payable until the Covered Person is eligible for coverage for Type III Dental Expenses.]]

For the purpose of these benefits only, the item in the EXCLUSIONS part that excludes procedures that are cosmetic in nature will not apply.

Nothing contained in this Certificate Amendment will be held to affect any of the terms of the Group Certificate other than as stated herein.

This Certificate Amendment is part of the Group Certificate. It should be kept with your Group Certificate which contains the principal provisions of the group policy.

[*Donald A. Stewart.*]

[Chief Executive Officer]

GROUP CERTIFICATE AMENDMENT: COSMETIC

SUN LIFE ASSURANCE COMPANY OF CANADA certifies that it has issued and delivered a Certificate Amendment to

[POLICYHOLDER: THE POLICYHOLDER NAMED ON THE FACE PAGE OF THE GROUP CERTIFICATE

EFFECTIVE DATE: THE BENEFITS DESCRIBED IN THIS CERTIFICATE AMENDMENT ARE EFFECTIVE ON THE LATER OF THE EMPLOYER'S EFFECTIVE DATE OR THE DATE THE BENEFIT BECOMES EFFECTIVE UNDER THE EMPLOYER'S PLAN

AMENDING GROUP POLICY NO.: THE POLICY NUMBER THAT IS SHOWN ON THE FACE PAGE OF THE GROUP CERTIFICATE AND THAT IS APPLICABLE TO DENTAL EXPENSE BENEFITS]

This Certificate Amendment forms a part of your Group Certificate which describes the provisions of the group policy specified above.

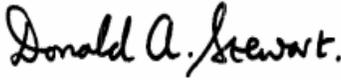
The Certificate is changed as follows:

The Certificate is changed by the addition of the following Vision Care Benefits:

Nothing contained in this Certificate Amendment will be held to affect any of the terms of the policy as outlined in the Group Certificate other than as stated herein.

[[This Certificate Amendment will not be effective with respect to: (1) any Employee not Actively At Work on its effective date and (2) any Dependent of such Employee, until such Employee is again Actively At Work or (3) any Employee whose insurance is being continued in accordance with any continuance of insurance provision on the effective date of this Certificate Amendment.]]

This Certificate Amendment is part of the Group Certificate. It should be kept with your Group Certificate which contains the principal provisions of the group policy.

[]

[Chief Executive Officer]

VISION CARE EXPENSE BENEFITS SCHEDULE EMPLOYEE [[AND DEPENDENTS]]

Schedule Plan

Covered Expense	Maximum Benefit*	Special Limitations
Eye Examination by an M.D.	<u>\$50.00</u>	Limited to one exam in any <u>24</u> consecutive month period
Eye Examination by an O.D.	<u>\$35.00</u>	Limited to one exam in any <u>24</u> consecutive month period
Frames	<u>\$50.00</u>	Limited to one pair in any <u>24</u> consecutive month period [[and to initial frames and to replacement frames when existing frames are not compatible with new lenses]]
Lenses:		Limited to 2 lenses in any <u>24</u> consecutive month period
Single	<u>\$18.75</u> per lens	
Bifocal	<u>\$35.00</u> per lens	
Trifocal	<u>\$45.00</u> per lens	
Lenticular	<u>\$56.25</u> per lens	
Contact Lenses	<u>\$25.00</u> per lens	[[Limited to one pair in any <u>24</u> consecutive month period]] and/or [[to <u>\$50</u> in any <u>24</u> consecutive month period]] [[to <u>\$50</u> per Lifetime.]] [[Payable only when visual acuity is not correctable to 20/70 in the better eye with conventional lenses but is correctable to 20/70 with contact lenses.]]
In any <u>24</u> consecutive month period, per person coverage is limited to:		
1. One routine eye examination; and		
2. One pair of frames and lenses; or one pair of contact lenses.		

* After applicable Deductible.

The Per Person Deductible is \$100 [[in any 24 consecutive month period.]] [[per Lifetime.]].

The Maximum Family Deductible is \$300 [[in any 24 consecutive month period.]] [[per Lifetime.]]

Coinsurance Plan

Covered Expense	% of Covered Expenses Payable*	Special Limitations
Type A Eye Examination	<u>50%</u>	Payable only when an eye refraction is performed. Limited to one exam in any <u>24</u> consecutive month period
Type B Frames and Lenses	<u>50%</u>	Limited to one pair in any <u>24</u> consecutive month period [[and to initial frames and to replacement frames when existing frames are not compatible with new lenses]]
Type C Contact Lenses	<u>50%</u>	[[Limited to one pair in any <u>24</u> consecutive month period]] and/or [[to <u>\$50</u> per in any <u>24</u> consecutive month period]] [[to <u>\$50</u> per Lifetime.]] [[Payable only when visual acuity is not correctable to 20/70 in the better eye with conventional lenses but is correctable to 20/70 with contact lenses.]]
In any <u>24</u> consecutive month period, per person coverage is limited to:		
1. One routine eye examination; and		
2. One pair of frames and lenses; or one pair of contact lenses; and		
3. <u>\$100</u> .		

* After applicable deductible.

The Per Person Deductible is \$100 [[per Calendar Year.]] [[per Lifetime.]].

The Maximum Family Deductible is \$300 [[per Calendar Year.]] [[per Lifetime.]]

Conditions under which Benefits are Payable

We will pay benefits for Vision Care Expenses as shown in the SCHEDULE subject to the following:

1. For a Covered Person who incurs covered Vision Care Expenses in excess of any applicable Deductible for a 24 consecutive month period; and
2. Our payment of benefits is subject to all of the terms and conditions of the policy.

[[Benefits Payable

If a Covered Person incurs covered Vision Care Expenses in excess of the Deductible, we will pay to you a benefit equal to the lesser of the actual charge or the amount shown in the SCHEDULE, subject to any [[Calendar Year]] [[Lifetime]] benefit maximum.]]

[[Benefits Payable

If a Covered Person incurs covered Vision Care Expenses in excess of the Deductible, we will pay to you a benefit equal to the applicable percentage shown in the SCHEDULE, subject to the [[Calendar Year]] [[Lifetime]] benefit maximum shown .]]

[Exclusions

Vision Care Expense Benefits do not include and no benefits are provided for:

1. Any procedures, services or supplies which are included as covered medical expense under a medical expense benefits plan;
2. Orthoptics, vision training, subnormal vision aids;
3. Plain or prescription sunglasses or other special purpose vision aids, or additional charges resulting from customized or designer features;
4. Medical or surgical treatment of the eyes;
5. Replacement of lost or broken lenses and/or frames;
6. Replacement of existing lenses except when required by a change in prescription;
7. Duplicate glasses, lenses, or frames;
8. Services or materials not listed in the SCHEDULE or which are not necessary to restore normal visual acuity;
9. Service or supply rendered by someone who:
 - a. normally lives in the Covered Person's home; or
 - b. is a member of your immediate family. Immediate family is limited to you, your spouse, and parents, brothers, sisters or children of either you or your spouse, whether related by blood or marriage;
10. Charges incurred or treatment rendered unless there is a legal obligation to pay whether or not there is insurance;
11. Charges resulting from an accidental bodily injury arising out of, or in the course of employment for wages or profit, or from any sickness for which benefits are provided under any Workers' Compensation Law or any similar legislation.]

<i>SERFF Tracking Number:</i>	<i>SNLF-125759955</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Sun Life Assurance Company of Canada</i>	<i>State Tracking Number:</i>	<i>39833</i>
<i>Company Tracking Number:</i>	<i>SLOC DENTAL 2008</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>Group Dental</i>		
<i>Project Name/Number:</i>	<i>SLOC Dental 2008/SLOC Dental 2008</i>		

Rate Information

Rate data does NOT apply to filing.

<i>SERFF Tracking Number:</i>	<i>SNLF-125759955</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Sun Life Assurance Company of Canada</i>	<i>State Tracking Number:</i>	<i>39833</i>
<i>Company Tracking Number:</i>	<i>SLOC DENTAL 2008</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>Group Dental</i>		
<i>Project Name/Number:</i>	<i>SLOC Dental 2008/SLOC Dental 2008</i>		

Supporting Document Schedules

Satisfied -Name:	Certification/Notice	Review Status:	Approved-Closed	08/16/2008
Comments:				
Attachment:	Flesch certification.pdf			

Satisfied -Name:	Application	Review Status:	Approved-Closed	08/16/2008
Comments:	Please see Form Schedule tab			

Satisfied -Name:	Cover letter & NAIC Transmittal	Review Status:	Approved-Closed	08/16/2008
Comments:				
Attachments:	AR Sub Ltr RG-MET.pdf NAIC T-form.pdf			

Satisfied -Name:	List of previously approved forms (SLHIC)	Review Status:	Approved-Closed	08/16/2008
Comments:				
Attachment:	AR Forms (SLHIC).pdf			

Satisfied -Name:	Dental QA 06-08 AG	Review Status:	Approved-Closed	08/16/2008
Comments:				
Attachment:	Dental QA 06-08 AG.pdf			

Review Status:

SERFF Tracking Number: SNLF-125759955 *State:* Arkansas
Filing Company: Sun Life Assurance Company of Canada *State Tracking Number:* 39833
Company Tracking Number: SLOC DENTAL 2008
TOI: H10G Group Health - Dental *Sub-TOI:* H10G.000 Health - Dental
Product Name: Group Dental
Project Name/Number: SLOC Dental 2008/SLOC Dental 2008

Satisfied -Name: Explanation of Variables Approved-Closed 08/16/2008

Comments:

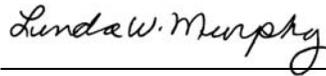
Attachments:

EOV POI.pdf
EOV DEN PPO.pdf

CERTIFICATION

This is to certify that the attached Form Numbers GA-A (94), GP-A-1 through -6 and GC-A-1 et al have achieved Flesch Reading Ease Scores of 52.4, 50.2 and 50.3 respectively and comply with the requirements of Arkansas Stat. Ann. §§66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

SUN LIFE ASSURANCE COMPANY OF CANADA



Linda W. Murphy
Compliance Officer

July 22, 2008



Sun Life Assurance Company of Canada
One Sun Life Executive Park
Wellesley Hills, MA 02481

August 4, 2008

Ms. Julie Benafield Bowman
Commissioner of Insurance
Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

RE: SUN LIFE ASSURANCE COMPANY OF CANADA
NAIC #: 80802; FEIN: 38-1082080
See attached list of Group Dental Policy and Certificate Forms

Dear Commissioner Bowman:

We are submitting the forms identified on the attached list for review and approval for use by Sun Life Assurance Company of Canada. These forms are new and not intended to replace any other forms currently in use.

These forms, including the forms numbers, are substantially similar to forms that were previously approved by the Department for use by Sun Life and Health Insurance Company (U.S.) formerly known as Genworth Life and Health Insurance Company. We have enclosed a list of the policy and certificate forms previously approved by your Department, including a description of the forms and their approval dates.

These forms are designed to provide group dental coverage in the following manner:

1. On a direct issue basis. The policy form will be issued in your state to groups recognized as eligible for group insurance in accordance with state insurance laws, rules and regulations, i.e. employer groups, union groups, etc.
2. On an out-of-state group trust basis. Coverage may be offered in your state to participating employers under a policy issued to a multiple employer trust situated in Rhode Island. The trustee/policyholder for these funds is BankNewport, located at 747 Aquidneck Ave, Middletown, Rhode Island 02842.

Please note that Sun Life Assurance Company of Canada is not creating new trusts. Rather, Sun Life has become the Settlor through the amendment and restatement of the existing Multiple Employer Trusts under which Genworth Life and Health Insurance Company was formerly the named Settlor directly or through assignment. This is being done because Sun Life Assurance Company of Canada will be the principal insurance carrier through which Sun Life Financial Employee Benefits Group will provide group insurance benefits to the marketplace.

With regard to marketing information, this program will be offered on a contributory or non-contributory basis, where the insured may be required to contribute none, all, or a portion of the premium. Coverage will be marketed through agent/broker solicitation. This program is exempt from filing in our domiciliary state, Michigan.

Sun Life Assurance Company of Canada (SLOC) has access to the Dentemax network, as an affiliated company, through the agreement between Health Care Exchange, Ltd (dba DenteMax) of Southfield Michigan and Sun Life and Health Insurance Company (U.S.). DenteMax is a wholly-owned subsidiary of Blue Cross Blue Shield of Michigan. DenteMax develops and maintains dental provider networks and uses the services of an NCQA certified credentialing verification organization. SLOC will not be entering into direct contracts with providers. The contracts will be between DenteMax and the providers.

The forms are in final print, subject to minor variations in formatting, duplexing, shading and fonts. Any items intended to be variable are bracketed. An Explanation of Variable parameters is enclosed, along with other all other filing requirements. As a point of information, variable data may vary from case to case. For example, the nature and structure of a group may require that certain terms be changed to fit the specific group. Amounts may vary or provisions may be modified to fit a specific policyholder's request. There may be other variations that may be changed as a result of negotiations between the policyholder and the Company. Please be assured that variable data will never exclude or limit provisions required by the jurisdiction in which the group policy is issued. With respect to mandated requirements, benefits greater than the mandates may be provided, where permitted.

Attached to this filing are any applicable state required fees, transmittal forms, and certifications.

If you have any questions or comments regarding this submission, please contact me at: (860) 737-1083, or email me at Ellen.thibodeau@sunlife.com.

Sincerely,

Ellen Thibodeau

Compliance Consultant
State Filing, WIN 370
Fax: (860) 737-6598

**FORMS BEING SUBMITTED FOR USE WITH
SUN LIFE ASSURANCE COMPANY OF CANADA
GROUP CERTIFICATE FORM SERIES: GC-A
PRODUCT: GROUP DENTAL INSURANCE**

Group Policy Forms

GA-A (94)	Application
GP-A-1	Agreement to Insure
GP-A-2	Subsidiary and Affiliated Employers
GP-A-3	Incorporation Provisions
GP-A-4	Termination Provision
GP-A-5	Premiums
GP-A-6	General Provisions

Description

Group Policy Riders

GP-AR	Blank Rider
-------	-------------

Description

Group Certificate Forms

GC-A-1	Cover page
GC-A-AR DEN DISC (07)	Appeals
GC-A-1 (07)	Insurance Schedule
GC-A-2	Table of Contents
GC-A-3 (07)	Definitions
GC-A-3A (06)	Definitions (Cont.)
GC-A-3B (06)	Definitions (Cont.)
GC-A-3C (07)	Definitions (Cont.)
GC-A-3D (07)	Definitions (Cont.)
GC-A-4 (07)	Employee Insurance
GC-A-5 (07)	Dependents Coverage
GC-A-5A (06)	Dependents Coverage (Cont.)
GC-A-6 (06)	Determination of Benefits
GC-A-6A (07)	Determination of Benefits (Cont.)
GC-A-6B (06)	Determination of Benefits (Cont.)
GC-A-6C (07)	Determination of Benefits (Cont.)
GC-A-6D (06)	Determination of Benefits (Cont.)
GC-A-7 (07)	Covered Dental Expenses
GC-A-7A (07)	Covered Dental Expenses (Cont.)
GC-A-7B (06)	Covered Dental Expenses (Cont.)
GC-A-7C (07)	Covered Dental Expenses (Cont.)
GC-A-7D (07)	Covered Dental Expenses (Cont.)
GC-A-7 SCHED (06)	Covered Dental Expenses (Cont.)
GC-A-8 (07)	Exclusions
GC-A-8A (06)	Exclusions (Cont.)
GC-A-8B (06)	Exclusions (Cont.)
GC-A-9	Coordination of Benefits
GC-A-9A	Coordination of Benefits (Cont.)
GC-A-9B	Coordination of Benefits (Cont.)
GC-A-10 (06)	Termination Provisions
GC-A-10B (06)	USERRA Notice
GC-A-11	General Provisions
GC-A-12 (97)	General Dental Provisions
GC-A-12A	General Dental Provisions (Cont.)

Description

Group Certificate Amendment

GC-CA	Blank Amendment
GC-CA VISION	Vision Benefits
GC-CA DEN TKOVER (07)	Dental Takeover Provisions
GC-CA COS (07)	Optional Cosmetic Benefits

Description

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	ARKANSAS					
2.	Department Use Only						
	State Tracking ID						
3.	Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
	Sun Life Assurance Company of Canada One Sun Life Executive Park Wellesley Hills, MA 02481	MI	Life and Health	549	80802	38-1082080	
4.	Contact Name & Address	Telephone #	Fax #	E-mail Address			
	Ellen Thibodeau 175 Addison Road; P.O. Box 725 Windsor, CT 06095-0725	860-737-1083 Toll Free: 1-800-451-2513, ext. 1083	860-737-6598	Ellen.thibodeau@sunlife.com			
5.	Requested Filing Mode	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____					
6.	Company Tracking Number	SNLF-125759955					
7.	<input checked="" type="checkbox"/> New Submission	<input type="checkbox"/> Resubmission	Previous file # _____				
8.	Market	<input type="checkbox"/> Individual <input type="checkbox"/> Franchise <input type="checkbox"/> Small <input type="checkbox"/> Large <input checked="" type="checkbox"/> Small and Large <input checked="" type="checkbox"/> Employer <input checked="" type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input checked="" type="checkbox"/> Trust <input checked="" type="checkbox"/> Other: _____ Labor Union					
9.	Type of Insurance	H10G Group Health - Dental					
10.	Product Coding Matrix Filing Code	H10G.000 Health - Dental					
11.	Submitted Documents	<input checked="" type="checkbox"/> FORMS <input checked="" type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input checked="" type="checkbox"/> Certificate <input type="checkbox"/> Application/Enrollment <input checked="" type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising <input type="checkbox"/> Schedule of Benefits <input type="checkbox"/> Other <u>Rates</u> <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate <input type="checkbox"/> FILING OTHER THAN FORM OR RATE: Please explain: _____ <u>SUPPORTING DOCUMENTATION</u> <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreements <input checked="" type="checkbox"/> Statement of Variability <input checked="" type="checkbox"/> Certifications <input type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other _____					

12.	Filing Submission Date	August 4, 2008	
13	Filing Fee (If required)	Amount <u> \$20.00 </u>	Check Date <u> </u>
		Retalutory <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Check Number <u> </u>
14.	Date of Domiciliary Approval	Exempt from filing.	
15.	Filing Description:		
	<p>We are submitting the forms identified on the attached list for review and approval for use by Sun Life Assurance Company of Canada. These forms are new and not intended to replace any other forms currently in use.</p> <p>These forms, including the forms numbers, are substantially similar to forms that were previously approved by the Department for use by Sun Life and Health Insurance Company (U.S.) formerly known as Genworth Life and Health Insurance Company. We have enclosed a list of the policy and certificate forms previously approved by your Department, including a description of the forms and their approval dates.</p> <p>These forms are designed to provide group dental coverage in the following manner:</p> <ol style="list-style-type: none"> 1. On a direct issue basis. The policy form will be issued in your state to groups recognized as eligible for group insurance in accordance with state insurance laws, rules and regulations, i.e. employer groups, union groups, etc. 2. On an out-of-state group trust basis. Coverage may be offered in your state to participating employers under a policy issued to a multiple employer trust situated in Rhode Island. The trustee/policyholder for these funds is BankNewport, located at 747 Aquideneck Ave, Middletown, Rhode Island 02842. <p>Please note that Sun Life Assurance Company of Canada is not creating new trusts. Rather, Sun Life has become the Settlor through the amendment and restatement of the existing Multiple Employer Trusts under which Genworth Life and Health Insurance Company was formerly the named Settlor directly or through assignment. This is being done because Sun Life Assurance Company of Canada will be the principal insurance carrier through which Sun Life Financial Employee Benefits Group will provide group insurance benefits to the marketplace.</p> <p>With regard to marketing information, this program will be offered on a contributory or non-contributory basis, where the insured may be required to contribute none, all, or a portion of the premium. Coverage will be marketed through agent/broker solicitation. This program is exempt from filing in our domiciliary state, Michigan.</p> <p>Sun Life Assurance Company of Canada (SLOC) has access to the Dentemax network, as an affiliated company, through the agreement between Health Care Exchange, Ltd (dba DenteMax) of Southfield Michigan and Sun Life and Health Insurance Company (U.S.). DenteMax is a wholly-owned subsidiary of Blue Cross Blue Shield of Michigan. DenteMax develops and maintains dental provider networks and uses the services of an NCQA certified credentialing verification organization. SLOC will not be entering into direct contracts with providers. The contracts will be between DenteMax and the providers.</p> <p>The forms are in final print, subject to minor variations in formatting, duplexing, shading and fonts. Any items intended to be variable are bracketed. An Explanation of Variable parameters is enclosed, along with other all other filing requirements. As a point of information, variable data may vary from case to case. For example, the nature and structure of a group may require that certain terms be changed to fit the specific group. Amounts may vary or provisions may be modified to fit a specific policyholder's request. There may be other variations that may be changed as a result of negotiations between the policyholder and the Company. Please be assured that variable data will never exclude or limit provisions required by the jurisdiction in which the group policy is issued. With respect to mandated requirements, benefits greater than the mandates may be provided, where permitted.</p> <p>Attached to this filing are any applicable state required fees, transmittal forms, and certifications.</p>		

16.	Certification (If required)		
	<p>I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of <u>Arkansas</u>.</p>		
	Print Name <u> Ellen Thibodeau </u>	Title <u> Compliance Consultant </u>	
	Signature <u> <i>Ellen Thibodeau</i> </u>	Date: <u> August 4, 2008 </u>	

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number		GA-A (94)
This filing corresponds to rate filing company tracking number		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Application	GA-A (94)	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Application For Group Insurance			
02	Policy Cover Page	GP-A-1	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Agreement to Insure			
03	Policy Insert Page	GP-A-2	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Eligible Employer			
04	Policy Insert Page	GP-A-3	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Incorporation Provisions			
05	Policy Insert Page	GP-A-4	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Termination Provisions			
06	Policy Insert Page	GP-A-5	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Premiums			
07	Policy Insert Page	GP-A-6	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	General Provisions			
08	Policy Rider	GP-AR	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Blank Rider			
09	Certificate Insert page	GC-A-1	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Cover Page			
10	Certificate Insert page	GC-A-AR DEN DISC (07)	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Dental Disclosure			
11	Certificate Insert Page	GC-A-1 (07)	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Insurance Schedule			

LH FFA-1

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number		GA-A (94)
This filing corresponds to rate filing company tracking number		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
12	Certificate Insert Page	GC-A-2	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Table of Contents			
13	Certificate Insert Page	GC-A-3 (07)	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Definitions			
14	Certificate Insert Page	GC-A-3A (06)	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Definitions (Cont.)			
15	Certificate Insert Page	GC-A-3B (06)	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Definitions (Cont.)			
16	Certificate Insert Page	GC-A-3C (07)	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Definitions (Cont.)			
17	Certificate Insert Page	GC-A-3D (07)	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Definitions (Cont.)			
18	Certificate Insert Page	GC-A-4 (07)	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Employee Insurance			
19	Certificate Insert Page	GC-A-5 (07)	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Dependent Coverage			
20	Certificate Insert Page	GC-A-5A (06)	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Dependent Coverage (Cont.)			
21	Certificate Insert Page	GC-A-6 (06)	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Determination of Benefits			

LH FFA-1

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number	GA-A (94)	
This filing corresponds to rate filing company tracking number		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
22	Certificate Insert Page	GC-A-6A (07)	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Determination of Benefits (Cont.)			
23	Certificate Insert Page	GC-A-6B (06)	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Determination of Benefits (Cont.)			
24	Certificate Insert Page	GC-A-6C (07)	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Determination of Benefits (Cont.)			
25	Certificate Insert Page	GC-A-6D (06)	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Determination of Benefits (Cont.)			
26	Certificate Insert Page	GC-A-7 (07)	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Covered Dental Expenses			
27	Certificate Insert Page	GC-A-7A (07)	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Covered Dental Expenses (Cont.)			
28	Certificate Insert Page	GC-A-7B (06)	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Covered Dental Expenses (Cont.)			
29	Certificate Insert Page	GC-A-7C (07)	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Covered Dental Expenses (Cont.)			
30	Certificate Insert Page	GC-A-7D (07)	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Covered Dental Expenses (Cont.)			
31	Certificate Insert Page	GC-A-7 SCHED (06)	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Covered Dental Expenses (Cont.)			

LH FFA-1

17.	Form Filing Attachment
This filing transmittal is part of company tracking number	GA-A (94)
This filing corresponds to rate filing company tracking number	

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
32	Certificate Insert Page	GC-A-8 (07)	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Exclusions			
33	Certificate Insert Page	GC-A-8A (06)	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Exclusions (Cont.)			
34	Certificate Insert Page	GC-A-8B (06)	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Exclusions (Cont.)			
35	Certificate Insert Page	GC-A-9	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Coordination of Benefits			
36	Certificate Insert Page	GC-A-9A	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Coordination of Benefits (Cont.)			
37	Certificate Insert Page	GC-A-9B	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Coordination of Benefits (Cont.)			
38	Certificate Insert Page	GC-A-10 (06)	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Termination Provisions			
39	Certificate Insert Page	GC-A-10B (06)	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Uniformed Services Employment and Re-employment Rights Act			
40	Certificate Insert Page	GC-A-11	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	General Provisions			
41	Certificate Insert Page	GC-A-12 (97)	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	General Dental Provisions			

17.	Form Filing Attachment
This filing transmittal is part of company tracking number	GA-A (94)
This filing corresponds to rate filing company tracking number	

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
42	Certificate Insert Page	GC-A-12A	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	General Dental Provisions (Cont.)			
43	Certificate Amendment	GC-CA DEN TKOVER (07)	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Dental Takeover Provisions			
44	Certificate Amendment	GC-CA	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Blank Amendment			
45	Certificate Amendment	GC-CA COS (07)	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Optional Cosmetic Benefits			
46	Certificate Amendment	GC-CA VISION	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Optional Vision Care Benefits			
47			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
48			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
49			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
50			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
51			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	

18.		Rate Filing Attachment		
This filing transmittal is part of company tracking number		GA-A (94)		
This filing corresponds to form filing company tracking number				
Overall percentage rate indication (when applicable)				
Overall percentage rate impact for this filing		%		
	Document Name	Affected Form Numbers		Previous State Filing Number
	Description			
01			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
02			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	

LH RFA-1

**SUN LIFE AND HEALTH INSURANCE COMPANY (U.S.)
GROUP POLICY OF INCORPORATION FORM SERIES: GP-A
STATE OF: ARKANSAS**

Group Policy Forms

	<u>Description</u>
GA-A	Application
GP-A-1	Agreement to Insure
GP-A-2	Subsidiary and Affiliated Employers
GP-A-3	Incorporation Provisions
GP-A-4	Termination Provision
GP-A-5	Premiums
GP-A-6	General Provisions

Approval Date: 8-8-90

Group Policy Riders

	<u>Description</u>
GP-AR	Blank Rider

Approval Date: 8-8-90

**GROUP CERTIFICATE FORM SERIES: GC-A
PRODUCT: GROUP DENTAL INSURANCE**

Group Certificate Forms

	<u>Description</u>	<u>Approval Date:</u>
GC-A-1	Cover page	8-8-90
GC-A-AR DEN DISC (07)	Appeals	11-7-07
GC-A-1 (07)	Insurance Schedule	11-7-07
GC-A-2	Table of Contents	8-8-90
GC-A-3 (07)	Definitions	11-7-07
GC-A-3A (06)	Definitions (Cont.)	12-5-06
GC-A-3B (06)	Definitions (Cont.)	12-5-06
GC-A-3C (07)	Definitions (Cont.)	11-7-07
GC-A-3D (07)	Definitions (Cont.)	11-7-07
GC-A-4 (07)	Employee Insurance	11-7-07
GC-A-5 (07)	Dependents Coverage	11-7-07
GC-A-5A (06)	Dependents Coverage (Cont.)	12-5-06
GC-A-6 (06)	Determination of Benefits	12-5-06
GC-A-6A (07)	Determination of Benefits (Cont.)	11-7-07
GC-A-6B (06)	Determination of Benefits (Cont.)	12-5-06
GC-A-6C (07)	Determination of Benefits (Cont.)	11-7-07
GC-A-6D (06)	Determination of Benefits (Cont.)	12-5-06
GC-A-7 (07)	Covered Dental Expenses	11-7-07
GC-A-7A (07)	Covered Dental Expenses (Cont.)	11-7-07
GC-A-7B (06)	Covered Dental Expenses (Cont.)	12-5-06
GC-A-7C (07)	Covered Dental Expenses (Cont.)	11-7-07
GC-A-7D (07)	Covered Dental Expenses (Cont.)	11-7-07
GC-A-7 SCHED (06)	Covered Dental Expenses (Cont.)	12-5-06
GC-A-8 (07)	Exclusions	11-7-07
GC-A-8A (06)	Exclusions (Cont.)	12-5-06
GC-A-8B (06)	Exclusions (Cont.)	12-5-06
GC-A-9	Coordination of Benefits	8-8-90
GC-A-9A	Coordination of Benefits (Cont.)	8-8-90
GC-A-9B	Coordination of Benefits (Cont.)	8-8-90
GC-A-10 (06)	Termination Provisions	12-5-06
GC-A-10B (06)	USERRA Notice	12-5-06
GC-A-11	General Provisions	8-8-90
GC-A-12 (97)	General Dental Provisions	7-23-97
GC-A-12A	General Dental Provisions (Cont.)	8-8-90

Group Certificate Amendment

	<u>Description</u>	<u>Approval Date:</u>
GC-CA	Blank Amendment	8-8-90
GC-CA VISION	Vision Benefits	8-9-00
GC-CA DEN TKOVER (07)	Dental Takeover Provisions	11-7-07
GC-CA COS (07)	Optional Cosmetic Benefits	11-7-07



Quality Assurance Program Dental

**Sun Life Financial
Employee Benefits Group**

GOALS

Both Sun Life Financial Employee Benefits Group (EBG) and our contracted vendors maintain Quality Assurance (QA) programs to help ensure the highest quality of dental care delivery to our covered persons. The goals of EBG's program are:

- Monitor the activities of EBG dental operations that affect insureds
- Monitor the activities of our dental vendors' operations that affect insureds
- Improve EBG's operational performance resulting in higher satisfaction of insureds
- Ensure compliance with state and federal laws

ORGANIZATIONAL STRUCTURE

EBG Oversight Committee (EOC)

The EBG Oversight Committee (EOC) is responsible for the dental QA program. The EOC evaluates issues, identifies trends and recommends corrective actions as necessary. The Committee meets quarterly and periodically reports the results of its activities to the Vice President – Dental Product, for presentation to the EBG Senior Leadership Team. EOC members include:

- Compliance Officer
- Dental Networks Director
- Manager, Dental TRU
- Dental Product Consultant
- Compliance Consultant
- Other representatives as needed

Quality Assurance Committee (QAC)

The Quality Assurance Committee (QAC) is responsible for continuous quality improvement of the retrospective utilization review program. QAC evaluates claim issues, identifies claims trends and emerging treatments, and recommends corrective actions. QAC holds quarterly meetings and reports its findings to EOC. QAC members include:

- Manager Dental Benefits
- Claims Administrator
- Dental Consultant(s)
- Manager, Dental TRU
- Other representatives as needed.

PROGRAM ACTIVITIES

The Committee is responsible for overseeing the QA activities of EBG as well as our vendors. EBG uses outside vendors for provider network development and maintenance. These vendors perform QA monitoring, reporting, and related activities. These activities include; credentialing and recredentialing of all providers, establishing and maintaining practice standards, the appeals processes for practitioner credentialing issues, and maintaining an understanding of and following all state and federal guidelines and regulations.

Our network vendors are required to maintain the appropriate appeals processes, make changes in the provider networks, provide appropriate correspondence of all findings to the providers, and keep records of all such activities and correspondence. Neither EBG nor its contracted vendors maintain claimant dependent information, as might be found in a DHMO, and therefore cannot accurately evaluate clinical outcomes.

EBG requires yearly reports from our vendors on QA/QI activity, credentialing and network maintenance issues. Additionally, at least every two years, the Oversight Committee reviews vendors' policies and procedures related to credentialing, recredentialing, monitoring of national and local databases (including state licensing boards), actions related to network maintenance, and internal QA and QI processes. As appropriate, we report the findings of our reviews to the vendors for appropriate action.

The EOC is also responsible for periodically assessing the EBG Retrospective Utilization Review program and for coordinating the retrospective UR program with other dental management activity, including quality assurance, credentialing, provider contracting, data reporting, grievance procedures, processes for assessing satisfaction of covered persons, and risk management. .

EBG maintains a Quality Assurance program designed to insure continuous quality improvement of the retrospective utilization review program of EBG and our contracted UR vendors. Most of the EBG derived data comes from retrospective claims reviews, appeals, and complaints. EBG also maintains a complaint database to aid in QA and QI monitoring. :

- Conducts periodic and random reviews of decisions, paying particular attention to patterns of claim denials, patterns of care outside standard guidelines, evidence of unbundling or up-coding, and clinical data suggesting reduced quality of care
- Monitors compliance with state and federal requirements for assuring confidentiality of clinical and patient information.
- Monitors call center statistics to insure adherence to established standards, and state and federal requirements
- Monitors Provider quality issues to insure adherence to established UR standards
- Monitors time service and quality statistics to insure adherence to established standards and state and federal requirements
- Monitors availability of licensed dental consultants for timely review.
- Reviews appeal and grievance determinations and adherence to P&P
- Monitors customer satisfaction
- Provides results of its findings to the Oversight Committee

GROUP POLICY OF INCORPORATION VARIATIONS

Application and Policy: GA-A (94), GP-A-1, GP-A-2, GP-A-3, GP-A-4, GP-A-5, GP-A-6
Riders: GP-AR

The [bracketed] and/or underscored material is intended to be illustrative and variable to accommodate the requirements of individual policyholders.

FORM #	PROVISION	VARIATION
GA-A (94)	Application for Group Insurance	Policyholder name and address, policy number and signature are specific to each individual policyholder. Insurer's address may vary to reflect future changes.
GP-A-1	Policyholder	Policy may be issued to an employer, trustee group or labor union. Employees may vary to read Members.
	Policy Number, Policy Effective Date, Policy Anniversary, State of Issue, Premium Due Date	Specific to each individual policyholder/employer.
	Officer's signature and title	Will vary to reflect future changes.
GP-A-2	Subsidiary and Affiliated Employers	Policyholder may vary to read Employer. Text in double brackets will be included as submitted or deleted.
GP-A-3	Certificates	Will vary to include the coverage(s) specific to each individual policyholder.
	Insurance Schedule	Employee may vary to read Member. Policyholder may vary to read Employer
GP-A-4	Termination Provisions	Employee may vary to read Member. 31 days may vary to 60 days or 90 days. When policy is issued to a trustee group, the termination provisions will vary to include the references to Employer and the Employer's participation in the Trust. 2 may vary up to 10.
GP-A-5	Premiums	Employer may vary to read Policyholder. Policyholder may vary to read Employer. Employee may vary to read Member. Text in double brackets may be omitted when policy is not issued to a trustee group. 6 may vary up to 36. Rates included will vary in accordance with particular policyholder's plan of insurance and the benefits and provisions relating thereto.
GP-A-6	31 Day Grace Period To Pay Premium Due	31 may vary to 60 or 90. Text in double brackets may be omitted when policy is not issued to a trustee group.
	Information That We May Need	Text in double brackets may be omitted when policy is not issued to a trustee group.
	Certificates of Insurance	Employee may vary to read Member
GP-AR	Rider	When variable language is to be amended, the paragraph will contain a description stating clearly what part of the policy is to be changed and will reflect the change that has to be made in the variable wording. For example, an Employer may have a name change, or may subsequently request a change in the grace period.

Explanation Of Variability-Arkansas
Forms GC-A-1 et al

The [bracketed] and/or underscored material is intended to be illustrative and variable to accommodate the requirements of individual policyholders. Text in [[double brackets]] may be included as submitted or deleted in its entirety. Coverage for Type II, III and/or IV Expenses may be omitted and any references to such expenses will be deleted. Procedures within an Expense Type may be moved to another Expense Type. Any reference to dependents will be deleted if the Employer chooses to provide coverage for employees only. References to Calendar Year may be changed to Benefit Year at the Policyholder's request. Language may be changed to reflect benefits mandated by your state laws or regulations or federal legislation. In addition, language may vary as follows:

Form #	Provision	Variation
GC-A-1	Policyholder	Policy may be issued to an employer, trustee group or labor union
	Effective Date, Account #, Group Policy #, State of Issue	Specific to a particular policyholder/employer.
	Notice	Late entrant paragraph may be omitted based on plan design. Officer's signature and title may vary to reflect future changes.
GC-A-AR DEN DISC (07)	Disclosure	Dental PPO Network sections may be omitted for indemnity plans. Dental Network information will vary with the network chosen.
GC-A-2	Table of Contents	Will reflect the benefits and provisions relating to a particular employer. Telephone number may vary to reflect future changes.
GC-A-1 (07)	Employee	Will vary to include all of the employer's employees or members in a union or all of any class or classes thereby determined by conditions pertaining to their employment/membership. When pertaining to membership, any references to Employee(s) will be changed to Member(s)
	Date of Eligibility	Determined by policyholder based on conditions pertaining to employment/membership
	Schedule of Dental Benefits	Reflects plan design and Policyholder selection; deductible may vary between \$0 and \$500; the maximum family deductible may be deleted or may be up to three times the per person deductible; the deductible may be Calendar Year or Lifetime; the deductible may be separate by each expense type, apply to all expense types or apply to type II and III expenses only; the per person maximum benefit may vary between \$250 and \$4,000; the maximum family benefit may be deleted or may be up to three times the per person maximum benefit; The calendar year maximums for Type II, Type III and Type IV expenses may vary between \$250 and \$2,000 or may be omitted; coverage for Type II, Type III and/or Type IV expenses may be omitted and any references to such expenses will be deleted; reference to dependent coverage will be deleted if the Policyholder chooses to provide coverage for employees only; references to vision care may be deleted based on Policyholder selection. In-Network coinsurance may vary as follows: Type I – 10%-100%, Type II –10%-100%, Type III – 10%-100%, Type IV – 10%-100%. Out-of-Network coinsurance may vary as follows: Type I – 10%-100%, Type II –10%-100%, Type III – 0%-100%, Type IV – 10%-100%. Coinsurance differentials will not exceed 25% . Type III may be excluded for out of network providers. Benefits payable will be in accordance with Policyholder selection; out of network expenses may be based on Usual and Customary Charges, Schedule Charges, Allowable Charges or all Type I, II and III benefits may be based on Schedule Amounts.

GC-A-3 (07)	Actively At Work	References to actively at work requirements and Employer may be omitted, references to employment may be changed to membership and references to employee may be changed to member when the policy is to cover groups other than employer/employee groups. References to full-time employment will be omitted when part-time employees are covered.
	Allowable Charge	May be included based on plan design
	Annual Election Period	May be included based on plan design
	Annual Plan Selection Period	May be included based on plan design
	Calendar Year	May be changed to Benefit Year and include the specific policy year of the Policyholder
	Child	Age may vary based on policyholder selection and state mandates. May be omitted for Employee only coverage. May include coverage for child of a domestic partner when such coverage is requested by the policyholder.
	Covered Person	Will vary to omit reference to dependents when dependent coverage is not provided.
GC-A-3A (06)	Dental Prophylaxis	Text that begins "For benefits purposes".... will be omitted when the policyholder has elected to provide coverage for periodontal maintenance.
	Dependent	May be omitted when dependent coverage is not provided. Domestic Partner may be included when requested by the policyholder. Item 2-a may be deleted if requested by the Policyholder.
	Domestic Partner	May be included when if requested by the Policyholder. "opposite sex or" may be deleted at the request of the Policyholder.
GC-A-3B (06)	Eligible Employee	References to Employee may be changed to Member. Item 3 and Item beginning " If your earnings'... will be deleted if eligibility is based on membership. .
	Employee	May vary to include all of the employer's employees or members in a union or all of any class/classes determined by conditions pertaining to employment/membership. When pertaining to membership, any references to Employee will be changed to Member. References to Employer/Employer's may be changed to Policyholder/Policyholder's. Hours per week may vary at the request of the policyholder.
	Employer (Eligible Employer)	References to Employer may be changed to Policyholder.
	Full-time Student	Will be omitted when Dependent coverage is not included or policyholder's plan does not require full-time student status.
GC-A-3C (07)	Handicapped Child	Will be omitted when Dependent coverage is not included. References to full-time student status will be deleted when policy has no full-time student requirement. Reference to the Employer/Eligible Employer may be changed to policyholder. Ages will vary in accordance with policyholder request and state mandates.
	Incurred Date	May be deleted in its entirety when only Type I expenses are covered. Type III and/or IV services may be omitted based on plan design.
	Late Entrant	May be omitted based on plan design
	Non-PPO Expenses	May be omitted based on plan design
	Non-PPO Provider	May be omitted based on plan design

GC-A-3D (07)	Orthodontic Treatment	May be omitted based on plan design
	PPO	May be omitted based on plan design
	PPO Expenses	May be omitted based on plan design
	PPO Provider	May be omitted based on plan design
	Retired Employee	May be included based on policyholder requirements. Employee may be changed to Member.
	Schedule Amount	May be omitted based on plan design
	Schedule Charge	May be omitted based on plan design
	You	Employee may be changed to Member.
GC-A-4 (07)	Date of Eligibility (Waiting Period)	References to actively at work requirements and Employer may be omitted, references to employment may be changed to membership and references to employee may be changed to member when the policy is to cover groups other than employer/employee groups. References to full-time employment will be omitted when part-time employees are covered. "Alternate Plan" language may be omitted based on plan design.
	Conditions of Insurability	Employee/Employer may be changed to Member/Policyholder. May include annual election or Late Entrant Provision; 31 days may vary to 60 days
	Annual Election Period	May be omitted based on plan design.
	Annual Plan Selection Period	May be omitted based on plan design.
	Effective Date of Insurance	Text that references actively at work requirement may be deleted when eligibility is not based on employment. Text referencing annual election period may be omitted based on plan design.
	When Coverage Starts	May be deleted based on Policyholder selection; reference to deferral of Types II, III and/or IV expenses may be deleted based on Policyholder selection. Deferral ranges from 6 months through 36 months. Coverage may be deferred for all employees/members or new employees/members only. When plan design does not include PPO, text referencing PPO and non-PPO Providers will be omitted.
	Limitation on Late Entrants	Entire provision may be omitted based on policyholder selection. Coverage for Type II expenses may be deferred for up to 12 months after a covered person has been insured. Coverage for Type III and/or IV Expenses may be deferred for up to 24 months after a covered person has been insured. Text that begins "to the lesser of"... may be omitted based on plan design.
GC-A-5 (07)	Dependent Coverage	Part may be omitted when the policyholder does not elect dependent coverage.
	Date of Eligibility	Domestic partner reference may be omitted based on Policyholder selection. Text that begins "If you and your spouse"... May be omitted based on policyholder selection. Reference to "or Domestic Partner" will be omitted when such coverage is not included.
	Conditions of Insurability	May vary to include Domestic Partner at policyholder's request; may include annual election or Late Entrant provision; 31 days may vary to 60 days.
	Effective Date of Insurance	Based on plan design, may include Annual Election Period language
	Annual Election Period	May be omitted based on plan design.
	When Coverage Starts	May be deleted based on Policyholder selection; reference to deferral of Types II, III and/or IV expenses may be deleted based on Policyholder selection. Deferral ranges from 6 months through 36 months. Coverage may be deferred for all employees/members or new employees/members only. When plan design does not include PPO, text referencing PPO and non-PPO Providers will be omitted.

GC-A-5A (06)	Limitation on Late Entrants	Entire provision may be omitted based on policyholder selection. Coverage for Type II expenses may be deferred for up to 12 months after a covered person has been insured. Coverage for Type III and/or IV Expenses may be deferred for up to 24 months after a covered person has been insured. Text that begins "to the lesser of"... may be omitted base on policyholder selection.
GC-A-6 (06)	Pre-Determination of Benefits	Entire provision may be deleted if Type I only coverage; endodontic, periodontal, surgical, prosthodontics and/or orthodontics may be deleted based on plan design; the Pre-Determination amount may vary from \$300 to \$500
	Conditions Under Which Benefits Are Payable	May vary based on policyholder selection of Calendar Year and Lifetime Maximums for Types III, IV and Vision; may vary based on Policyholder selection of deductible for Vision coverage
	Benefits Payable with respect to Type I, Type II and Type III COVERED DENTAL EXPENSES	Reference to Type II and/or III Expenses may be omitted based on plan design; reference to deductible may be omitted based on plan design. May vary to indicate that benefits will be payable in accordance with the Schedule Amounts shown in PART 5.
GC-A-6A (07)	Benefits Payable for Type IV COVERED DENTAL EXPENSES	Entire provision may be omitted when orthodontic coverage is not provided.
	Deductible	May vary based on Policyholder selection: deductible may be Calendar Year or Lifetime, Vision deductible may combine with Dental deductible; family deductible may be deleted, 3 month carryover may apply; separate deductible for PPO and non-PPO expenses may apply.
	Calendar Year Maximum Benefit	May vary based on Policyholder selection: reference to Type II and/or Type III expenses may be deleted; reference to vision care expenses may be deleted; may be a limit for Type II, Type III and/or Type IV specifically; may include Type IV Calendar Year maximum; separate maximums for PPO and non-PPO expenses may apply.
GC-A-6B (06)	Maximum Carryover	Provision may be omitted in its entirety; threshold amount may vary from \$350 to \$1,000; amounts added to the carryover account per calendar year vary from \$350 to \$1,000; Carryover Account maximums may vary from \$1, 000 to \$6,000.
GC-A-6C (07)	Lifetime Maximum Benefit	May be included when Policyholder selects Type IV coverage. Vision Care Expenses may be included in the maximum benefit. Based on plan design, coverage may be limited for the first 2 years of coverage under the plan; separate maximums for PPO and non-PPO expenses may apply. Alternate text for Lifetime Maximum Benefit provision may be included based on plan design.
	Alternate Dental Treatment, Favorable Result of Treatment, Benefits for Temporary Work	Provisions may be deleted in their entirety when coverage is provided only for Type I expenses.
GC-A-6D (06)	Benefits After Termination	Provision will be deleted in its entirety when coverage is provided only for Type I Expenses. References to Type III and/or Type IV coverage will be deleted based on plan design. Child ages may vary. Item 3 may be deleted in its entirety if adult orthodontic coverage is provided.

GC-A-7 (07)	Covered Dental Expenses: Type 1 Dental Services	References to PPO and Non-PPO providers may be omitted based on plan design. Text may vary to indicate that benefits for charges by Non-PPO Providers are the lesser of the Usual Charge or the Customary Charge; the lesser of the Usual Charge or Customary Charge or the Schedule Charge; or the lesser of the Usual Charge or Customary Charge or the Allowable Charge or the Schedule Charge; Basis for charges may vary by Type of service. Frequencies may vary to reflect plan design and Policyholder selection; procedures may be moved to a different expense type based on policyholder selection. Procedures that are specific to dependent children, i.e. child prophylaxis, sealants will be omitted when there is no dependent coverage.
	Oral Evaluation	"Evaluation" may vary to read "Examination". Based on plan design, options for: "Benefits will be based on the covered amount for a periodic oral evaluation" and/or "Not payable in addition to periodontal maintenance." Frequency options include: Limited to 1 time in any 6 consecutive month period. Limited to 1 time in any 12 consecutive month period. Limited to 2 times in any 12 consecutive month period Limited to 1 time in any 18 consecutive month period Limited to 1 time in any 24 consecutive month period Limited to 1 time in any 36 consecutive month period Limited to 1 per Calendar Year Limited to 2 per Calendar year No frequency limit
	Consultation	May be omitted. Frequency may vary to reflect plan design and Policyholder selection. Frequency options include: Limited to 1 time in any 6 consecutive month period. Limited to 1 time in any 12 consecutive month period. Limited to 1 per Calendar Year Limited to 2 per Calendar Year
	Bite-wing X-rays	Frequency may vary to reflect plan design and Policyholder selection. Frequency options include: Limited to 1 time in any 6 consecutive month period Limited to 1 time in any 12 consecutive month period Limited to 2 times in any 12 consecutive month period. Limited to 1 time in any 18 consecutive month period Limited to 1 time in any 24 consecutive month period Limited to 1 time in any 36 consecutive month period Limited to once per Calendar Year. Limited to 2 times in any Calendar Year. No frequency limit.

	Dental Prophylaxis	<p>May vary to distinguish between Adult and Child Prophylaxis. Child age may vary from 14 through 19</p> <p>Frequency options include:</p> <p>No limit</p> <p>Limited to 1 time in any 3 consecutive month period for adult prophylaxis</p> <p>Limited to 1 time in any 4 consecutive month period for adult prophylaxis</p> <p>Limited to 1 time in any 6 consecutive month period</p> <p>Limited to 1 time in any 12 consecutive month period.</p> <p>Limited to 2 times in any 12 consecutive month period</p> <p>Limited to 1 time in any 18 consecutive month period</p> <p>Limited to 1 time in any 24 consecutive month period</p> <p>Limited to 1 time in any 36 consecutive month period</p> <p>Limited to 1 per Calendar Year</p> <p>Limited to 2 per Calendar year</p> <p>Limited to 4 per Calendar Year for adult prophylaxis</p>
	Fluoride Treatments	<p>May be deleted for Employee/Member only plans. Child age may vary from 14 through 19.</p> <p>May vary to include adults. Frequency options include:</p> <p>Limited to 1 time in any 6 consecutive month period</p> <p>Limited to 1 time in any 12 consecutive month period</p> <p>Limited to 1 time in any Calendar Year</p> <p>Limited to 2 times in any Calendar Year</p> <p>No frequency limit.</p>
	Space Maintainers	<p>May be deleted for Employee/Member only plans. May be excluded at the request of the Policyholder. Child age may vary from 14 through 19.</p>
	Sealants	<p>May be included at the request of the Policyholder. Child age may vary from 14 through 19. Frequency options include:</p> <p>Limited to once per lifetime</p> <p>Limited to twice per lifetime</p> <p>Limited to once in any 36 consecutive months</p> <p>Limited to once in any 60 consecutive months</p>
GC-A-7A (07)	Type II Dental Services	<p>Text regarding deferral of coverage may be omitted based on plan design. Text regarding deferral of coverage for services rendered by PPO and non-PPO providers may be omitted based on plan design. Reference to "A Covered Person" may be changed to "If you become an Eligible Employee after the date your Employer becomes an Eligible Employer you"..... when deferral is applicable only to new employees.</p> <p>Frequencies may vary to reflect plan design and Policyholder selection; procedures may be moved to a different expense type based on policyholder selection; may be omitted in its entirety based on policyholder selection.</p>
	Occlusal Guard	<p>Frequency may vary to reflect plan design and policyholder selection. Frequency options include:</p> <p>Limited to 1 time in any 12 consecutive month period</p> <p>Limited to 1 time in any 18 consecutive month period</p> <p>Limited to 1 time in any 24 consecutive month period</p> <p>Limited to 1 time in any 36 consecutive month period</p>

	Oral Evaluation – Problem Focused	<p>May be omitted.</p> <p>Frequency may vary to reflect plan design and Policyholder selection. Frequency options include:</p> <p>Limited to 1 time in any 6 consecutive month period.</p> <p>Limited to 1 time in any 12 consecutive month period.</p> <p>Limited to 2 times in any 12 consecutive month period</p> <p>Limited to 1 time in any 18 consecutive month period</p> <p>Limited to 1 time in any 24 consecutive month period</p> <p>Limited to 1 time in any 36 consecutive month period</p> <p>Limited to 1 per Calendar Year</p> <p>Limited to 2 per Calendar Year</p> <p>No frequency limit</p>
	Extraoral X-rays	<p>Frequency may vary to reflect plan design and Policyholder selection. Frequency options include:</p> <p>Limited to 1 time in any 6 consecutive month period</p> <p>Limited to 1 time in any 12 consecutive month period</p> <p>Limited to 1 time in any 18 consecutive month period</p> <p>Limited to 1 time in any 24 consecutive month period</p> <p>Limited to 1 time in any 36 consecutive month period</p>
	Palliative Treatment	"Including sedative fillings" may be omitted.
	Diagnostic Casts	<p>Frequency may vary to reflect plan design and Policyholder selection. Frequency options include:</p> <p>Limited to 1 time in any 24 consecutive month period</p> <p>Limited to 1 time in any 36 consecutive month period</p> <p>Limited to 1 time in any 48 consecutive month period</p>
	Complete Series or Panorex X-rays	<p>"Panorex or complete series" may be omitted from limitation wording. Frequency may vary to reflect plan design and Policyholder selection. Frequency options include:</p> <p>Limited to 1 in any 60 consecutive month period.</p> <p>Limited to 1 in any 48 consecutive month period.</p> <p>Limited to 1 in any 36 consecutive month period.</p> <p>Limited to 1 in any 24 consecutive month period.</p> <p>No frequency limitation</p>
	Individual Periapical X-Rays	<p>Frequency may vary to reflect plan design and Policyholder selection. Frequency options include:</p> <p>Limited to 4 films in any 12 consecutive month period.</p> <p>Limited to 4 films per Calendar Year.</p>
	Amalgam Restoration	<p>Option for no frequency limitation. Option for the limitation to apply to each tooth surface.</p> <p>Frequency options include:</p> <p>Limited to 1 time in any 12 consecutive month period</p> <p>Limited to 1 time in any 18 consecutive month period</p> <p>Limited to 1 time in any 24 consecutive month period</p> <p>Limited to 1 time in any 36 consecutive month period</p>

	Resin-based Composite Restoration	<p>"Resin-based" may vary to read "Silicate, Plastic and Composite". Option for no frequency limitation. Option for the limitation to apply to each tooth surface. Option to cover on posterior teeth. Frequency options include:</p> <p>Limited to 1 time in any 12 consecutive month period Limited to 1 time in any 18 consecutive month period Limited to 1 time in any 24 consecutive month period Limited to 1 time in any 36 consecutive month period</p>
	Stainless Steel Crowns	"Charges that exceed those payable for base metal will not be Covered Expenses" may be omitted.
	Repairs to Full Dentures, Partial Dentures, Bridges	<p>Option to exclude coverage. Option for no frequency limitation. Frequency options include repairs or adjustments done more than:</p> <p>12 months after the initial insertion 24 months after the initial insertion</p>
	Root Canal Therapy	<p>Frequency options include:</p> <p>Limited to 1 time per tooth in any 24 month period No frequency limitation</p>
GC-A-7B (06)	Scaling and Root Planing	<p>Option to exclude coverage. Frequency options include:</p> <p>Limited to 1 time per quadrant in any 12 consecutive month period. Limited to 1 time per quadrant in any 18 consecutive month period. Limited to 1 time per quadrant in any 24 consecutive month period. Limited to 1 time per quadrant in any 36 consecutive month period. Limited to 1 time per quadrant in any 48 consecutive month period. No frequency limitation</p>
	Periodontal Maintenance	<p>Option to exclude coverage. "Not payable in addition to dental prophylaxis" may be omitted. Option for coverage in addition to Dental Prophylaxis. Frequency options include :</p> <p>Limited to 1 per Calendar Year. Limited to 2 per Calendar Year. Limited to 3 per Calendar Year. Limited to 4 per Calendar Year. Limited to 1 time in any 12 consecutive month period. Limited to 2 times in any 12 consecutive month period. Limited to 3 times in any 12 consecutive month period. Limited to 4 times in any 12 consecutive month period.</p>
	Therapeutic Parenteral Drug Administration	Option to exclude coverage.
	General Anesthesia	Limitation may be omitted in its entirety. Option to provide coverage only when required in conjunction with a covered surgical procedure.
	Gingivectomy, Osseous Surgery, Osseous Graft	<p>Option to exclude coverage. Frequency options include:</p> <p>One procedure per area of the mouth in any 12 months One procedure per area of the mouth in any 18 months One procedure per area of the mouth in any 24 months One procedure per area of the mouth in any 36 months No frequency limit</p>

	Occlusal Adjustment	Option to exclude coverage. Frequency options include: One procedure per area of the mouth in any 12 months One procedure per area of the mouth in any 18 months One procedure per area of the mouth in any 24 months One procedure per area of the mouth in any 36 months No frequency limit
GC-A-7C (07)	Type III Dental Services	Text regarding deferral of coverage may be omitted based on plan design. Text regarding deferral of coverage for services rendered by PPO and non-PPO providers may be omitted based on plan design. Reference to "A Covered Person" may be changed to "If you become an Eligible Employee after the date your Employer becomes an Eligible Employer you"..... when deferral is applicable only to new employees. Frequencies may vary to reflect plan design and Policyholder selection; procedures may be moved to a different expense type based on policyholder selection. May be omitted in its entirety based on policyholder selection.
	Initial Inlays and Onlays	Limitation may vary to indicate "Covered only if the tooth cannot be restored by silver fillings.
	Porcelain Restorations	Option to exclude coverage. May vary to read "covered only if the tooth cannot be restored by a filling or by other means"...
	Crown Buildup or Core Buildup	Option to exclude coverage.
	Initial Crowns	Option to exclude charges that exceed those payable for base metal.
	Replacement Crowns	Option to exclude charges that exceed those payable for base metal.
	Replacement Implant Crowns	Option to exclude coverage. Option to exclude charges that exceed those payable for base metal.
	Implant Crown	Option to exclude charges that exceed those payable for base metal.
	Implant	Option to exclude coverage.
	Initial Full or Partial Dentures	Option to exclude charges that exceed those payable for base metal.
	Relining Dentures	Frequency options include: Limited to relining done more than 12 months after the initial insertion. Limited to relining done more than 24 months after the initial insertion.
	Rebasing Dentures	Frequency options include: Limited to rebasing done more than 12 months after the initial insertion. Limited to rebasing done more than 24 months after the initial insertion.
	Replacement of Full or Partial Dentures	Option to exclude charges that exceed those payable for base metal.
	Initial Fixed Bridges	Option to exclude charges that exceed those payable for base metal. Option to pay as a partial denture.
	Replacement of Fixed Bridges	Option to exclude charges that exceed those payable for base metal. Option to pay as a partial denture.

GC-A-7D (07)	Type IV Orthodontic Dental Services	May be omitted in its entirety based on policyholder selection. Text regarding deferral of coverage may be omitted based on plan design. Text regarding deferral of coverage for services rendered by PPO and non-PPO providers may be omitted based on plan design. Reference to "A Covered Person" may be changed to "If you become an Eligible Employee after the date your Employer becomes an Eligible Employer you"..... when deferral is applicable only to new employees.
GC-A-7 SCHED (06)		Alternate pages to GC-A-7 (07), GC-A -7A (07), GC-A-7B (06) and GC-A-7C (07). Benefits for Covered Expenses are 100% of the Schedule Amounts shown. Policyholder may choose from several schedule options. Schedule Amounts shown illustrate lowest and highest amounts available. Frequencies may vary to reflect plan design and Policyholder selection. Frequency options and limitations may vary as indicated in our explanation for Forms GC-A-7 (07), GC-A -7A (07), GC-A-7B (06) and GC-A-7C (07). Procedures in double brackets may be omitted at the request of the policyholder. Procedures that are specific to dependent children, i.e. child prophylaxis, child fluoride will be omitted when there is no dependent coverage.
GC-A-8 (07)	Item 5	Option to exclude coverage. Option to exclude coverage for prosthodontics replaced within certain time periods. Prosthodontic replacement periods may vary based on plan design. Options vary in 12 month increments from 60 through 120 months. Option for requirement for insured to be covered for 12, 24, or 36 months prior to replacement.
	Items 6 and 7	Coverage for implants may be excluded based on plan design.
GC-A-8A (06)	Item 10	Coverage for crown buildups may be excluded based on plan design.
	Item 11	Coverage for sedative filling may be excluded based on plan design.
	Item 12	Charges for treatment of TMJ may be included or omitted based on plan design.
GC-A-8B (06)	Item 13	References to Domestic Partner may be omitted when such coverage is not included.
	Item 17	Reference to implantology will be omitted when implants are covered
	Item 19	Will be included when the policyholder has not elected to provide Orthodontic coverage. Text beginning...."for Covered Persons"... will be included when the policyholder has not elect coverage for adult orthodontic treatment
	Item 20	Coverage for sealants may be excluded based on plan design.
GC-A-9B	Order of Benefit Determination	Item 3 may be omitted when the policyholder has not elected to provide dependent coverage.
GC-A-10 (06)	Termination of Employee and Dependent Insurance	If eligibility is based on membership, employee will be changed to member and item 1 will be deleted. References to Dependents will be deleted if the policyholder chooses to provide coverage to employees/members only. "On the date..." may vary to read "On the last day of the calendar month in which".... Layoff and leave of absence provisions – 2 months may vary up to 6 months References to full-time employment will be omitted when part-time employees are covered. Item 1-d, extending coverage to retired employees may be included/omitted based on policyholder selection The first item 6 may be deleted if the policy is issued to a trustee group. The second item 6 will be deleted if the policy is not issued to a trustee group. Item 7 may be omitted based on plan design
	Termination of Dependent Coverage Only	May be omitted in its entirety when the policyholder has not elected to provide dependent coverage. Item 4 may be expanded to include termination on the last day of the calendar year in which a Dependent Child ceases to be a Full-time Student. Item 5 may be omitted when domestic partner coverage is not included.

GC-A-11	General Provisions	If the Employer is the Policyholder, text in double brackets will be omitted. Employee may vary to read Member. Employer may vary to read Policyholder. References to Dependent(s) will be deleted if the policyholder chooses to provide coverage for employees only.
GC-A-12 (97) GC-A-12A	General Dental Provisions	If the Employer is the Policyholder, reference to “or Employer” will be omitted. References to Dependent(s) or other covered persons will be deleted if the policyholder chooses to provide coverage for employees only. Will be omitted when coverage for Type IV is omitted.
GC-CA DEN TKOVR (07)	Dental Takeover Provisions	May be omitted in its entirety.
	Exception to Maximum Carryover Provision	May be omitted based on plan design.
	Exception to Deductible and Maximum Benefit Provisions	Applicability to Maximum Benefit provision may be omitted based on plan design. Item 2 may be omitted when there is no 3 month carryover provision. Last sentence of this provision may be omitted based on plan design.
	Reduction to Lifetime Maximum Benefit	May be omitted based on plan design.
	Reduction to Calendar Year Maximum Benefit	May be omitted based on plan design.
	Exception to Exclusion Provision	May be omitted based on plan design.
GC-CA	Certificate Amendment	When variable language is to be amended, the paragraph will contain a description stating clearly what part of the policy is to be changed and will either reflect the change that has to be made in the variable wording or will identify the pages that are being substituted or added. For example, an Employer may have a name change, a Waiting Period change, a schedule change or may subsequently add coverage for sealants.
GC-CA COS (07)	Cosmetic Benefit	Option to provide benefits for bleaching only; Option to provide benefits for bleaching and cosmetic veneers. Schedule amount for bleaching only benefit may vary from \$10 to \$200. Maximum benefit for bleaching only benefit may vary from \$10 to \$200. Schedule amount for bleaching and cosmetic veneers may vary from \$20 to \$200. Maximum benefit for bleaching and cosmetic veneers may vary from \$50 to \$500. Covered Person age may vary from 14 to 19. Frequency options for veneers vary from 5 years through 10 years. Text that begins “If a Covered Person”... will be omitted when there is no Late Entrant provision. References to “the lesser of the Usual or Customary Charge or the Schedule Amount of ...” will be used for Schedule Plans only. References to coinsurance percentage for Type III Covered Expenses may be omitted based on plan design.
GC-CA VISION	Vision Care Expense Benefits Schedule	Benefits amounts, frequencies and deductible may vary based on employer selection. Deductible may be calendar year or lifetime.