SUN LIFE ASSURANCE COMPANY OF CANADA

Executive Office:
96 Worcester Street
Wellesley Hills, MA 02481

(800) 247-6875
www.sunlife.com/us

Sun Life Assurance Company of Canada certifies that it has issued and delivered a Group Insurance Policy to the Policyholder shown below insuring certain Employees of the Employer shown below.

Policy Number:	932864-001
Policy Effective Date:	October 1, 2019
Policyholder:	Earnhardt Management Company
Employer:	Earnhardt Management Company
Issue State:	Arizona
Amendment Effective Date:	October 1, 2024

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

This Certificate is governed by the laws of the Issue State shown above unless otherwise preempted by the federal Employee Retirement Income Security Act ("ERISA").

Signed at Wellesley Hills, Massachusetts.

Kevin Strain
President and Chief Executive Officer

Troy Krushel
Vice-President, Associate General Counsel and Corporate Secretary

Group Dental Certificate

Non-Participating

DISCLOSURE OF INFORMATION

This Disclosure provides you with information regarding your Group Dental Benefits. It is intended to clarify and to provide additional information about your plan. The Group Certificate provides detailed provisions of coverage including any limitations or restrictions that apply. **Read your certificate carefully.**

What is the Sun Life Dental PPO?
The Sun Life Dental PPO Policy is a group dental insurance program provided by us that uses a nationwide network of Dentists. Sun Life strives to provide the most comprehensive network of Dentists possible in all areas of the country. The Sun Life Dental PPO Network includes dentists that are contracted with Dental Health Alliance L.L.C.® (DHA®), a Sun Life affiliate, and dentists that are contracted with other, unaffiliated, dental PPO networks. In order to ensure that quality standards are met, DHA® uses a National Committee for Quality Assurance (NCQA) accredited organization to conduct credentials verification for its Dentists. The other dental PPO networks that Sun Life accesses also have credentialing policies and procedures that apply to their contracted Dentists. All Dentists have the right to participate in the DHA® network provided all credentialing criteria are met and they are willing to meet the terms and conditions for participation. The other dental PPO networks that Sun Life accesses have their own criteria for accepting Dentists into their networks.

Key features of this plan include:
- Insureds may receive services from providers of their choice; and
- Insureds may receive higher levels of benefits for dental services when choosing Participating Providers.

How do you find a provider in the network?
You may obtain provider directories by:
- contacting our Customer Service Department at 800-247-6875; or
- viewing the list of Participating Providers on our website at www.sunlife.com/findadentist.

It is possible that a provider may have left or joined the network since the publishing of the directory. You may contact Sun Life's Customer Service Department directly to report a directory inaccuracy.

How are providers in the network compensated?
Reimbursements to dental providers are based on various factors. When covered services are provided by a Participating Provider, charges are on a contracted fee-for-service basis. Whether a Participating Provider's contracted fees apply to non-covered services depends upon any applicable state law and, in some cases, whether the Participating Provider has elected to offer network fees on non-covered services.

The Participating Provider is not given an incentive or bonus that encourages withholding service or that influences referrals to specialists. If you want additional information about how Participating Providers are compensated, please contact us.

Is the provider allowed to discuss all Treatment options with you?
The Participating Provider contracts do not include "gag" clauses. The contracts do not prohibit the provider from discussing, with an Insured:
- the available Treatment options and services; or
- the compensation methodology.

What is a Pre-Determination of Benefits?
A Pre-Determination of Benefits allows an Insured to know, prior to receiving Treatment, the amount of benefits that may be payable. We recommend a Pre-Determination of Benefits for some services. These are described in the "Covered Dental Benefits" section of the Certificate. We will notify you and the Dentist of the benefits payable based upon the Course of Treatment that was submitted.

Pre-Determination of Benefits is not a guarantee of benefits under your dental Policy. You or your Dependents must meet the eligibility requirements and services must be Covered Dental Expenses for benefits to be payable. In addition, claims are processed in the order in which they are received.

Therefore, the service for which an Insured received a Pre-Determination of Benefits may not be payable if the Maximum Benefit was reached since the Pre-Determination was processed. **Please be sure to read the Certificate carefully to ensure coverage is provided under your Policy.**

Are claims subject to retrospective review?
Certain claims are subject to retrospective review to determine whether the supplies or services provided are Dentally Necessary as required by the Policy. Other than expenses for coverage that is required by state law (or for bleaching of teeth, if covered by your plan), expenses for Treatment or supplies that are not Dentally Necessary or are not within generally accepted standards of dental Treatment are not covered by the Policy.

What are your benefits?
The "Benefit Highlights" and "Covered Dental Benefits" sections of the Certificate contain information regarding benefits including benefit maximums and limitations. The "Benefit Highlights" section outlines the benefit levels for Treatment both in and out of network. It also includes information about your responsibility for payment related to coinsurance, deductibles and annual limits. In determining the amount of benefits payable, consideration will be given to alternate dental Treatment that will accomplish a professionally satisfactory result. If the Insured and the Dentist agree to a more costly method of Treatment, the excess amount will not be paid by us. If services are not covered by the Policy, you are responsible for full payment.

The "Exclusions" section of the Certificate contains information about charges for which no benefits are paid. Benefits are payable for Dentally Necessary Treatment, subject to all of the provisions of the Policy.

The following example illustrates benefit payments using both Participating and Non-Participating Providers. Your plan may differ in deductible and coinsurance levels. However, this example demonstrates the impact on benefits of using Non-Participating Providers.

This example assumes no cash deductible for Type I Dental Services; 100% coinsurance for Network Expenses rendered by a Participating Provider; and 90% coinsurance for Non-Network Expenses rendered by a Non-Participating Provider.

	Network Expenses (Participating Provider)	**Non-Network Expenses (Non-Participating Provider)**
$130 Covered Type I Dental Service		
Cash Deductible	None	None
Coinsurance Level Network Expense: 100% of Allowable Charge for Participating Providers ($108)	$108 (Allowable Charge) x100% (Coinsurance Level) $108	
Non-Network Expense: 90% of Allowable Charge for Non-Participating Providers ($125)		$125 (Allowable Charge) x90% (Coinsurance Level) $112.50
Plan Pays	$108	$112.50
You Pay	**$0**	**$17.50**

DISCLOSURE OF INFORMATION

Is your information kept confidential?
Dental records and other patient information will be released only upon written authorization from you. Such information may only be used *by us* to determine eligibility for benefits and to administer the Policy. We maintain physical, electronic, and procedural safeguards to protect the confidentiality of information provided to us.

What are our responsibilities regarding your rights?
We are committed to treating all our Insureds in a manner that respects their rights under the Policy. We expect the providers of care to treat our Insureds as they would any other patient in terms of care provided, accommodations, and timeliness of access to care.

The Sun Life Dental PPO does, sometimes, solicit information on Insured satisfaction.

How do you contact us?
You can contact us at:

Sun Life Assurance Company of Canada
Director, Dental Benefits
96 Worcester Street
Wellesley Hills, MA 02481
Toll-free telephone number: 800-247-6875
Hours: Monday - Friday 8:00 A.M. to 6:00 P.M. ET

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1. BENEFIT HIGHLIGHTS

EMPLOYEE, SPOUSE AND DEPENDENT CHILDREN DENTAL INSURANCE

Eligible Class: All Full-Time United States Employees working in the United States scheduled to work at least 30 hours per week, excluding Employees enrolled in the Employer's Alternate Plan

Eligibility Waiting Period: Until the first of the month coincident with or next following 2 months of employment

Deductible:

Per Person Deductible: $50 per Benefit Year

Only one deductible applies per Benefit Year if Type II and III Dental Expenses are Incurred. The deductible is waived for Type I Dental Expenses.

Maximum Benefit:

The Per Person Maximum Benefit for Type I, II and III Dental Expenses combined is:
$1,500 per Benefit Year.

Maximum Benefit Rollover (Preventive Rewards)

The Per Person Maximum Benefit Rollover for Type I Dental Expenses is:

Rollover Amount	Type I Paid Claims
Account Maximum	$1,250

Covered Dental Benefits

Unless otherwise specified, the following benefits will be payable based on the Allowable Charge. Refer to the Covered Dental Benefits section of this Certificate for additional information including limitations.

Type I Covered Dental Expenses
Payable at: 100% for Network Expenses
100% for Non-Network Expenses

Oral Evaluations
Bite Wing X-Rays
Dental Prophylaxis
Genetic Test
Fluoride Treatment
Space Maintainers
Sealants

Type II Covered Dental Expenses
Payable at: 90% for Network Expenses
80% for Non-Network Expenses

Intraoral Complete Series
Extraoral X-Rays
Intraoral Occlusal X-rays
Intraoral Periapical X-rays

Palliative Treatment
Scaling and Root Planing
Periodontal Maintenance
Localized Delivery of Time Release Anti-microbial Agents into Diseased Crevicular Tissue
Root Canal Therapy
Apicoectomy/Periradicular Surgery
Retrograde Filling
Hemisection
Pulpotomy
Root Amputation
Gingivectomy
Gingivoplasty
Osseous Surgery
Guided Tissue Regeneration
Osseous Graft
Pedicle Graft
Tissue Grafts
Crown Lengthening
Distal or Proximal Wedge Procedure
Simple Extraction
Amalgam Restoration
Composite Posterior Filling
Accession and examination of tissue
Pin Retention
Therapeutic Drug Injections
Consultation
Composite and Silicate Restorations

Type III Covered Dental Expenses
Payable at: 60% for Network Expenses
50% for Non-Network Expenses

Surgical Extraction
Alveoplasty
Vestibuloplasty
Removal of Lateral Exostosis
Frenectomy
Excision of Hyperplastic Tissue
Orantral Fistula Closure
Biopsy
Incision and Drainage
Tooth Re-implantation
General Anesthesia/IV Sedation
Stainless Steel Crowns
Crowns
Inlays and Onlays
Fixed Bridge
Removable Full or Partial Dentures
Repair/Recement Full Dentures, Partial Dentures, Crowns, Inlays
Crown Buildup
Post and Core
Tissue Conditioning
Veneers
Clasps and Rests
Relining Dentures, Rebasing Dentures
Denture Adjustments
Occlusal Guard

Contributions: The cost of your insurance is paid entirely by you.

2. DEFINITIONS

Account means the amount of an Insured's accumulated Rollover Amount for the Maximum Benefit Rollover.

Account Maximum means the maximum Rollover Amount that an Insured can store in their Account for the Maximum Benefit Rollover.

Actively at Work means that you perform all the regular duties of your job for a full work day at your Employer's normal place of business, a site approved by your Employer or a site where your Employer's business requires you to travel.

You are considered Actively at Work if you usually perform the regular duties of your job at your home as long as you can perform all the regular duties of your job for a full work day and could do so at your Employer's normal place of business.

You are considered Actively at Work on any day that is not your regular scheduled work day (e.g., you are on vacation or holiday) as long as you were Actively at Work on your immediately preceding scheduled work day, and you are neither Confined nor disabled due to an injury or sickness.

Allowable Charge means:

- with respect to Covered Dental Expenses provided by a Participating Provider, the pre-determined fee:
  - made available to us under any agreement; and
  - that a Participating Provider has agreed to charge for a given service.
- with respect to Covered Dental Expenses provided by a Non-Participating Provider, a fee level that is at the 90th percentile of the amount standardly charged for like Treatment, by other providers in the Locality where the service is Incurred.
- with respect to Covered Dental Expenses provided by a Contracting Provider, the lesser of:
  - a fee level that is at the 90th percentile of the amount standardly charged for like Treatment, by other providers in the Locality where the service is Incurred; or
  - the pre-determined fee made available to us under any agreement.

Alternate Plan means a plan of dental benefits, other than this plan, offered by your Employer and provided by us.

Benefit Waiting Period means the period of time that an Insured must be covered under the Policy before being eligible for specific dental services.

Benefit Year means a 12 month period determined by your Employer during which plan features such as deductibles and maximums accumulate and during which plan limitations may apply.

Confined or Confinement means confined to a hospital or similar facility.

Contracting Provider means a Dentist who provides dental services for Non-Network Expenses at the pre-determined Allowable Charge.

Course of Treatment means a planned program of one or more services for the Treatment of a diagnosed dental condition.

Covered Dental Expense means the lesser of the provider's billed charge or the Allowable Charge for any dental services when that service is:

- performed by a Dentist or Denturist;
- Dentally Necessary, as determined by us, for the dental care of an Insured; and
- determined by us to have a favorable prognosis.

2. DEFINITIONS

Dental Hygienist means someone who meets both of the following requirements:
- is currently licensed to practice dental hygiene by the state in which they practice; and
- is acting under the supervision of a Dentist.

Dentally Necessary means a service or Treatment that is appropriate for the diagnosis and in accordance with accepted dental standards. The service or Treatment must be essential for the care of the teeth and supporting tissues.

Dental Prophylaxis means 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. A multiple appointment cleaning shall be considered as a single prophylaxis.

Dentist means someone who meets both of the following requirements:
- is currently licensed to practice dentistry by the state in which they practice; and
- is acting within the scope of their license.

Denturist means someone who meets both of the following requirements:
- is currently licensed to make dentures by the state in which they practice; and
- is acting within the scope of their license.

Dependent means your insured Spouse and Dependent Children. Dependent does not include a person who is an Employee of your Employer unless you and your Spouse are each Employees of your Employer and you have or acquire a Dependent Child.

Dependent Child (Dependent Children) means your child under age 26.

Dependent Child includes:
- your step-child;
- a foster child placed with you by a licensed agency;
- a child for whom you have or your Spouse has legal guardianship of the child's person;
- your adopted child, including any child placed with you for adoption.

If an unmarried child is age 26 or older and is:
- incapable of self-sustaining employment because of an intellectual disability, developmental disability, or physical handicap; and
- chiefly dependent on you for their support;

that child will continue to be considered a Dependent Child under the Policy for as long as these conditions exist.

No person may be considered to be a Dependent Child of more than one Employee.

Dependent Child does not include:
- any person who is insured as an Employee;
- your married child whose employer sponsors Dental Insurance; or
- any person residing outside the United States or Canada. This exclusion does not apply to a Dependent Child who:
  - resides with you while you are on a temporary work assignment outside the United States; or
  - is a Full-time Student attending school outside of the United States.

Eligibility Waiting Period means the length of time you must be a member in an Eligible Class before you can apply for insurance. The Eligibility Waiting Period is shown in the Benefit Highlights. Any period of time you were Actively at Work for the Employer as a full-time Employee will count towards completion of the Eligibility Waiting Period.

2. DEFINITIONS

Employee means a person who is employed by the Employer within the United States, who is a U.S. citizen or a U.S. resident, scheduled to work at least the minimum hours shown in the Benefit Highlights, and paid regular earnings, and has a legitimate federal tax identification number. Employee does not include a seasonal or temporary employee whose annual work schedule is less than 12 months during a calendar year.

If you are an Employee and you are working on a temporary assignment outside of the United States for 12 months or less, you will be deemed to be working within the United States. If you are an Employee and you are working on a temporary assignment outside of the United States for more than 12 months, you will not be considered an Employee under the Policy unless we agree in Writing.

Employer means the Employer named on the cover page of this Certificate and includes any subsidiary or affiliated company named in the application.

Enrollment Period means the period of time each year not to exceed 30 days during which eligible Employees may elect, change, or cancel insurance under the Policy or elect to become covered under an Alternate Plan. The Enrollment Period cannot exceed 30 days or occur more than once in any 12-month period, unless we agree in Writing.

Family Member means: (a) your spouse or domestic partner and (b) the following relatives of you or your spouse or domestic partner: (1) parent; (2) grandparent; (3) child; (4) grandchild; (5) brother; (6) sister; (7) aunt; (8) uncle; (9) first cousin; (10) nephew or niece. This includes adopted, in-law and step-relatives.

Family Status Change means one of the following events:
- your marriage or divorce;
- the birth of your child;
- the adoption of a child by you;
- the placement of a child with you, pending adoption;
- the death of your Spouse or child;
- involuntary loss of other group dental coverage;
- loss of dental coverage under a state Medicaid plan;
- the commencement or termination of employment of your Spouse or Dependent Child;
- the change from part-time to full-time employment by you or your Spouse;
- the change from full-time to part-time employment by you or your Spouse; or
- the taking of an unpaid leave of absence by you or your Spouse.

Functioning Natural Tooth means that part of the tooth that is formed by the human body and is:
- performing its normal role in the chewing process in the upper or lower arch; and
- opposed in the other arch by another tooth or prosthetic replacement.

Incur, Incurs or Incurred means the following:
- if the Policy includes coverage for any of the following services, they will be considered Incurred if started and completed while insured under the Policy:
  - full or partial dentures are considered started on the date the final impression is made and completed on the date the final completed appliance is first inserted in the mouth;
  - fixed bridges, crowns, inlays, and onlays are considered started on the date the teeth are first prepared and completed on the date an appliance is cemented in place;
  - root canal therapy is considered started on the date the pulp chamber is opened and completed on the date a canal is permanently filled;
  - implants are considered started and completed on the date the implant is inserted; or
  - if the Policy includes coverage for Type IV services, those services will be considered Incurred on the date of insertion of bands or appliance; and
- all other Covered Dental Expenses will be considered Incurred on the date the service was rendered.

Insured means any person covered under the Policy.

2. DEFINITIONS

Late Entrant means:

- an Employee who does not enroll during the times specified in the “When must you enroll for Employee Dental Insurance?” section;
- a Spouse who you do not enroll during the times specified in the “When must you enroll for Spouse Dental insurance?” section;
- a Dependent Child who you do not enroll during the times specified in the “When must you enroll for Dependent Children Dental insurance?” section; or
- any Insured who requests reinstatement of insurance which was terminated while they remain eligible for insurance under the Policy.

Layoff means that you are temporarily not Actively at Work for a period of time your Employer agreed to in Writing. Your normal vacation time is not considered a temporary Layoff.

Leave of Absence means that you are temporarily not Actively at Work for a period of time your Employer agreed to in writing. Your normal vacation time is not considered a temporary Leave of Absence.

Locality means an area whose size is large enough, as determined by us, to give an accurate representation of standard charges for a type of dental service.

Network Expense means Covered Dental Expenses for services that are furnished by a Participating Provider.

Non-Network Expense means Covered Dental Expenses for services that are furnished by a Non-Participating Provider or Contracting Provider.

Non-Participating Provider means any Dentist who is not a Participating Provider and provides dental services for Non-Network Expenses payable based on the Allowable Charge or Contracting Provider who provides dental services for Non-Network Expenses at the pre-determined Allowable Charge.

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

Participating Provider means any Dentist who provides dental services for Network Expenses at the pre-determined Allowable Charge.

Participation in a Riot, Rebellion or Insurrection, the words "Participation" and "Riot" in this phrase mean:
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 your own defense, 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 firefighters.

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 a common intent and whether or not damage to person or property or unlawful act or acts is the intent or the consequence of such disorder.

Periodontal Maintenance means recall procedures for patients who have had surgical or non-surgical Treatment for periodontal disease. The procedures include examination, periodontal evaluation and any further scaling and root planing that is Dentally Necessary.

2. DEFINITIONS

Physician means a person who is operating within the scope of their license and is either:
- licensed in the United States as a medical doctor and authorized to practice medicine and prescribe and administer drugs or to perform surgery; or
- any other duly licensed medical practitioner who is deemed by applicable state or provincial law to have the same authority as a legally qualified medical doctor.

The Physician cannot be you, a business associate or any Family Member.

Policy means the group insurance policy under which this Certificate is issued.

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

Retirement means the first of the following to occur:
- the effective date of your Retirement benefits under:
  - any plan of a federal, state, county, municipal, association retirement system or public retirement, including Public Employees' Retirement System (PERS) or State Teachers' Retirement System (STRS) which you are eligible as a result of your employment with the Employer;
  - any Retirement plan the Employer sponsors; or
  - any Retirement plan to which the Employer:
    - makes contributions; or
    - has made contributions;
- the effective date of your Retirement benefits under the Social Security Act or any similar plan or act;
- the date, after you reach age 65, you terminate your employment with the Employer.

However, if you meet the definition of Employee and are receiving Retirement benefits under the Social Security Act, Public Employees' Retirement System (PERS), State Teachers' Retirement System (STRS) or similar plan or act, you will not be considered retired.

Rollover Amount means the dollar amount which may be added to an Insured's Account for the Maximum Benefit Rollover when benefits are received in a Benefit Year that do not exceed the Account Maximum.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable law.

Spouse means any individual who is a party to a marriage and under state, federal or provincial law is recognized as a spouse.

Spouse does not include:
- any person who is insured as an Employee; or
- any person residing outside the United States or Canada. This exclusion does not apply to your Spouse who resides with you while you are on a temporary work assignment outside the United States.

Treatment means a Dentist's consultation, care or services, or diagnostic measures.

We, Us, Our (we, us, our) means Sun Life Assurance Company of Canada or an affiliate company.

Written or Writing means a record which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable law.

You, Your (you, your) means an Employee who is eligible for insurance under the Policy.

3. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF EMPLOYEE INSURANCE

When are you eligible for Employee Dental Insurance?
You are initially eligible for Employee Dental Insurance on the latest of:

- October 1, 2019;
- the first day of the month coincident with or next following the date your Eligibility Waiting Period ends; or
- the date you first are Actively at Work in an Eligible Class.

You are also eligible for Employee Dental Insurance during any Enrollment Period or as a result of a Family Status Change, provided you are Actively at Work and in an Eligible Class.

When must you enroll for Employee Dental Insurance?
For Contributory Employee Dental Insurance, you must enroll within 31 days of the date you are initially eligible for Employee Dental Insurance.

If you do not enroll for insurance during your initial Enrollment Period, you will not be insured for any Contributory Employee Dental Insurance.

If you do not enroll for insurance during your initial Enrollment Period, you are a Late Entrant.

If you refuse your insurance and do not enroll when you are eligible, then you will not be allowed to enroll until the next Enrollment Period and you will be a Late Entrant.

When does Employee Dental Insurance start?
Employee Dental Insurance starts on the later of the date:

- you are eligible;
- you enroll; and
- you agree to make any required contribution toward the cost of insurance;

if you are Actively at Work on that date.

If you are not Actively at Work on that date, your insurance will not start until you resume being Actively at Work.

What are the Employee Benefit Waiting Periods?
If you are a Late Entrant you will be insured for Type I Dental Expenses on your Effective Date of Insurance. There are Benefit Waiting Periods for Type II and Type III Dental Expenses as shown below. The Benefit Waiting Periods begin on your Effective Date. The Benefit Waiting Period for:

- Type II Dental Expenses is 12 months except Restorations – 6 months.
- Type III Dental Expenses is 24 months.

The Benefit Waiting Periods shown above will not be applied if you were enrolled in the Prior Plan.

What happens if you are rehired by your Employer?
If you are rehired by your Employer within 1 month of the date your employment ends, your insurance may be reactivated. Your reactivated insurance will:

- be the same insurance for which you were insured prior to termination of employment;
- be subject to all the terms and provisions of the Policy.

If you had partially satisfied your Eligibility Waiting Period prior to your termination of employment, your previous time employed with your Employer will count towards completion of your Eligibility Waiting Period. Your Eligibility Date will be the later of the first day of the month coincident with or next following the date you are rehired or the first day of the month coincident with or next following the date you complete the Eligibility Waiting Period.

3. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF EMPLOYEE INSURANCE

If you are rehired and your insurance is reactivated within 90 days of the date your employment ends, you will retain the Rollover Amount in your Maximum Benefit Rollover Account prior to termination of employment.

If you are rehired by your Employer 1 month or later after the date your employment terminates, your coverage will not be reinstated. You will be eligible for insurance on the day after you complete a new Eligibility Waiting Period.

You must re-enroll within 31 days of your rehire date.

When does Employee Dental Insurance end?
Your Employee Dental Insurance under the Policy will end on the earliest of the following to occur:

- the date the Policy terminates;
- the last day for which any required premium has been paid for your Employee Dental Insurance;
- the date you notify us in Writing to cancel your Employee Dental Insurance; or
- the date you die.

Your Employee Dental Insurance will also end on the earliest of the following to occur, but coverage may be extended subject to any allowed continuation as specified in the Insurance Continuation section:

- the date you are no longer in an Eligible Class;
- the date you enter active duty in any armed service;
- the last day of the month in which you retire;
- the date your class is no longer included for insurance; or
- the last day of the month in which you are Actively at Work.

If your coverage has ended, can it be reinstated?
If your insurance ends for any reason other than you have voluntarily terminated your insurance, then you may apply to reinstate your insurance within 1 month from when your insurance ended. To reinstate your insurance, you must apply within 31 days after you return to being Actively at Work in an Eligible Class. Reinstatement will be effective on the later date when both of the following have occurred:

- you agree to make any required contribution toward the cost of your insurance; and
- you return to being Actively at Work.

Any Treatment occurring between your termination date and your reinstatement effective date will not be considered a Covered Expense.

A new Eligibility Waiting Period will not apply.

Your reinstated insurance will be:

- the insurance your Employer offers at the time of your reinstatement; and
- subject to all the terms and provisions of the Policy.

4. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF SPOUSE INSURANCE

When are you eligible for Spouse Dental Insurance?
If you are in an Eligible Class, you are initially eligible for Spouse Dental Insurance on the latest of:

- October 1, 2019;
- the date you are insured for Employee Dental Insurance; or
- the date you acquire a Spouse.

You are also eligible for Spouse Dental Insurance during any Enrollment Period or as a result of a Family Status Change, provided you are in an Eligible Class and have a Spouse.

When must you enroll for Spouse Dental Insurance?
For Contributory Spouse Dental Insurance, you must enroll within 31 days of the date you are initially eligible for Spouse Dental Insurance or within 31 days of the date of a Family Status Change or during any Enrollment Period or your Spouse will be a Late Entrant.

When does Spouse Dental Insurance start?
For Contributory Spouse Dental Insurance, Spouse Dental Insurance starts on the latest of the date:

- you are eligible for Spouse Dental Insurance;
- you are insured under the Policy for Employee Dental Insurance;
- you enroll for Spouse Dental Insurance; and
- you agree to make any required contribution toward the cost of insurance;

if you are Actively at Work on that date and your Spouse is not Confined on that date.

If you are not Actively at Work on that date, your Spouse Dental Insurance will not start until you resume being Actively at Work.

What are the Spouse Benefit Waiting Periods?
If you are a Late Entrant or your Spouse is a Late Entrant your Spouse will be insured for Type I Dental Expenses on your Spouse's Effective Date of Insurance. There are Benefit Waiting Periods for Type II and Type III Dental Expenses as shown below. The Benefit Waiting Periods for Late Entrants begin on your Spouse's Effective Date. The Benefit Waiting Period for:

- Type II Dental Expenses is 12 months except Restorations – 6 months.
- Type III Dental Expenses is 24 months.

The Benefit Waiting Periods shown above will not be applied if your Spouse was enrolled in the Prior Plan.

What if your Spouse is Confined?
If your Spouse is Confined on the date your Spouse Dental Insurance would normally start, your Spouse Dental Insurance will not start until your Spouse is no longer Confined.

When does Spouse Dental Insurance end?
Spouse Dental Insurance under the Policy will end on the earliest of the following to occur:

- the date the Policy terminates;
- the last day for which any required premium has been paid for your insurance or your Spouse Dental Insurance;
- the date you notify us in Writing to cancel your Spouse Dental Insurance;
- the date you die; or
- the date your Spouse dies.

Your Spouse Dental Insurance will also end on the earliest of the following to occur, but coverage may be extended subject to any allowed continuation as specified in the Insurance Continuation section:

- the date you are no longer in an Eligible Class;
- the date you are no longer insured under the Policy;
- the last day of the month in which your Spouse no longer meets the definition of Spouse as described in this Certificate;

- the date your Spouse enters active duty in any armed service;
- the last day of the month in which you retire;
- the date your class is no longer included for insurance; or
- the last day of the month in which you are Actively at Work.

5. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF DEPENDENT CHILDREN INSURANCE

When are you eligible for Dependent Children Dental Insurance?
If you are in an Eligible Class, then you are initially eligible for Dependent Children Dental Insurance on the latest of:

- October 1, 2019;
- the date you are insured for Employee Dental Insurance; or
- the date you acquire your Dependent Children.

You are also eligible for Dependent Children Dental Insurance during any Enrollment Period or as a result of a Family Status Change, provided you are in an Eligible Class and have one or more Dependent Children.

When must you enroll for Dependent Children Dental Insurance?
For Contributory Dependent Children Dental Insurance, you must enroll within 31 days of the later of the date:

- you are initially eligible for Dependent Children Dental Insurance; or
- your Dependent Child reaches age 3;

or your Dependent Child will be a Late Entrant unless you apply during any Enrollment Period or within 31 days of the date of a Family Status Change.

When does Dependent Children Dental Insurance start?
For Contributory Dependent Children Dental Insurance, Dependent Children Dental Insurance starts on the latest of the date:

- you are eligible for Dependent Children Dental Insurance;
- you are first insured under the Policy, for Employee Dental Insurance;
- you enroll for Dependent Children Dental Insurance; and
- you agree to make any required contribution toward the cost of insurance;

if you are Actively at Work and your Dependent Child is not Confined on that date.

If you are not Actively at Work, your Dependent Children Dental Insurance will not start until you resume being Actively at Work.

What are the Dependent Children Benefit Waiting Periods?
If you are a Late Entrant or your Dependent Child is a Late Entrant your Dependent Child will be insured for Type I Dental Expenses on your Dependent Child's Effective Date of Insurance. There are Benefit Waiting Periods for Type II and Type III Dental Expenses as shown below. The Benefit Waiting Periods for Late Entrants begin on your Dependent Child's Effective Date. The Benefit Waiting Period for:

- Type II Dental Expenses is 12 months except Restorations – 6 months.
- Type III Dental Expenses is 24 months.

The Benefit Waiting Periods shown above will not be applied if your Dependent Child was enrolled in the Prior Plan.

What if your Dependent Child is Confined?
If your Dependent Child is Confined on the date your Dependent Children Dental Insurance would normally start, your Dependent Children Dental Insurance will not start until your Dependent Child is no longer Confined. Confinement does not apply to a newborn child or a newly adopted child.

How does Dependent Children Dental Insurance apply to newborn children, newly placed foster children or newly adopted children?
If you are insured under the Policy but do not have Dependent Children Dental Insurance when a newborn child, newly placed foster child or newly adopted child becomes one of your Dependent Children, then such child will automatically be covered for 31 days from the date they become your Dependent Child. To continue coverage beyond 31 days, you must:

- enroll for Dependent Children Dental Insurance within 31 days from the date the newborn child, newly placed foster child or newly adopted child becomes your Dependent Child; and
- pay the required premium to continue your Dependent Children Dental Insurance.

5. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF DEPENDENT CHILDREN INSURANCE

If you are covered under the Policy and have Dependent Children Dental Insurance when a newborn, newly placed foster child or newly adopted child becomes one of your Dependent Children, then such child will automatically be covered.

When does Dependent Children Dental Insurance end?
Dependent Children Dental Insurance under the Policy will end on the earliest of the following to occur:

- the date the Policy terminates;
- the last day for which any required premium has been paid for your insurance or your Dependent Children Dental Insurance;
- the date you notify us in Writing to cancel your Dependent Children Dental Insurance;
- the date you die; or
- the date your Dependent Child dies, but only with respect to that person.

Your Dependent Children Dental Insurance will also end on the earliest of the following to occur, but coverage may be extended subject to any allowed continuation as specified in the Insurance Continuation section:

- the date you are no longer in an Eligible Class;
- the date you are no longer insured under the Policy;
- the last day of the month in which your Dependent Child no longer meets the definition of Dependent Child as described in this Certificate, but only with respect to that person;
- the date your Dependent Child enters active duty in any armed service, but only with respect to that person;
- the last day of the month in which you retire;
- the date your class is no longer included for insurance; or
- the last day of the month in which you are Actively at Work.

6. COVERED DENTAL BENEFITS

What is the Dental Benefit?
We will pay a Dental Benefit if an Insured Incurs Covered Dental Expenses for any of the services shown below. Payments for Covered Dental Expenses are based on the Allowable Charge and type of service – Type I, Type II or Type III. The percentage payable for each type of service is shown in the Benefit Highlights. Dental Benefits are only available for Covered Dental Expenses that are Incurred while an Insured is covered under the Policy.

Are you required to get a Pre-Determination of Benefits?
We recommend a Pre-Determination of Benefits for:

- extensive Treatment such as root canal therapy, crowns, bridges and periodontal Treatment, if those services are included under the Policy; or
- any Treatment for which charges will exceed $500.

We recommend that the Course of Treatment be submitted to us for review before Treatment begins. We will notify you and the Dentist of the benefits payable based upon the Course of Treatment. In determining the amount of benefits payable, we will consider 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.

Pre-Determination of Benefits is not required. If you do not submit a Pre-Determination of Benefits the amount of benefits payable by us is not affected.

What is the alternate dental Treatment benefit?
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. No alternate dental Treatment benefit is payable for any service that is not a Covered Dental Expense.

Under what conditions are benefits payable?
Our payment of benefits is subject to all the terms and conditions of the Policy. 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 that procedure will be payable.

What are providers entitled to collect from you?
If an Insured uses the services of a Participating Provider or a Contracting Provider for Covered Dental Expenses, those providers are entitled to collect from you the difference between the amount of benefits payable by us and the lesser of the provider's billed charge or the Allowable Charge. If we pay a benefit for an alternate dental Treatment, a Participating Provider or a Contracting Provider is entitled to collect from you the difference between the amount of benefits payable by us and the lesser of the provider's billed charge or the Allowable Charge for the service provided.

If an Insured uses the services of a Non-Participating 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.

What benefits are payable for Type I, Type II and Type III Covered Dental Expenses?
If during a Benefit Year an Insured Incurs Covered Dental Expenses in excess of the Deductible, the benefit payable will be:

- equal to the applicable percentage shown in the Benefit Highlights;
- subject to any Benefit Waiting Periods;
- limited to the Benefit Year Maximum Benefit; and
- limited to the Rollover Amount in an Insured's Maximum Benefit Rollover Account.

6. COVERED DENTAL BENEFITS

What is the Deductible?
The Per Person Deductible is the amount of Covered Dental Expenses that an Insured must Incur in a Benefit Year before any benefits are payable. The Per Person Deductible per Benefit Year for each type of Covered Dental Expense is shown in the Benefit Highlights. The amounts to be applied to meet the Deductible must be charges for Covered Dental Expenses.

If an Insured Incurs Covered Dental Expenses for Type I Services, those expenses are not subject to the Per Person Deductible.

What is the Benefit Year Maximum Benefit?
The Per Person Maximum Benefit in each Benefit Year for Type I, II and III Dental Expenses combined is shown in the Benefit Highlights. The Benefit Year Maximum Benefit applies to all periods of time the Insured is insured during a Benefit Year regardless of any interruptions in coverage for this insurance. This Maximum Benefit applies to all Covered Dental Expenses.

What is the Benefit Year Maximum Benefit Rollover (Preventive Rewards)?
The Per Person Maximum Benefit Rollover in each Benefit Year for Type I expenses is shown in the Benefit Highlights. An Insured may be eligible for a rollover amount of Type I benefits paid during the Benefit Year.

Rollover Amounts can accumulate and are saved up to the Account Maximum shown in the Benefit Highlights. If an Insured reaches the Benefit Year Maximum Benefit for Type I, Type II and Type III expenses, we may pay additional benefits above the Benefit Year Maximum Benefit up to the amount saved in an Insured's Account. The amount of the Rollover Amount stored in an Insured's Account may not be greater than the Account Maximum.

The Maximum Benefit Rollover applies to all periods of time an Insured is covered under the Policy during a Benefit Year. An Insured's Account Maximum may be eliminated, and the accumulated Rollover Amount lost, if an Insured has a break in coverage of more than 90 days, for any reason.

If the Policy first becomes effective in the last 3 months of the Employer's Benefit Year, this rollover benefit will not apply until the first day of the month of the first full Benefit Year. And, if the effective date of an Insured's dental coverage is in the last 3 months of the Employer's Benefit Year, this benefit will not apply to an Insured until the first day of the month of the next full Benefit Year. Rollover Amounts will not be applied to an Insured's Account Maximum until the Benefit Year that starts 1 year from the date this benefit first applies.

If charges for any Covered Dental Expenses are not payable for an Insured during the Benefit Waiting Periods for any services, this benefit will not apply to an Insured until the end of such period. If such period ends within the 3 months prior to the start of the Policy's next Benefit Year this benefit will not apply to an Insured until the next Benefit Year, and Rollover Amounts will not be applied to an Insured's Account until the Benefit Year that starts 1 year from the date this benefit first applies.

Does your Treatment have to have a favorable prognosis?
Benefits will be considered only for Treatment that we determine has a reasonably favorable prognosis of correcting the Insured's dental condition for a period of at least 3 years.

Are benefits payable for temporary work?
Benefits for temporary dental service including temporary prosthetics will be considered a part of the final dental service. By temporary prosthetics we mean any prosthetic inserted and used by an Insured for fewer than 12 months. Any prosthetic inserted and used by an Insured for at least 12 months will be considered permanent in nature.

6. COVERED DENTAL BENEFITS

Are any benefits payable after your insurance terminates?
No benefits are available after an Insured's insurance ends except that benefits are available:

- for procedures requiring multiple visits if the Treatment is started while an Insured is covered under the Policy and completed within 30 days after the Insured's insurance ends. Treatment is considered started when the tooth is irrevocably altered. This extension is limited to crowns, fixed bridges, inlays, onlays, full dentures, partial dentures and root canal therapy if such services are included under the Policy; and
- until the end of the calendar year quarter in which insurance ends, for Orthodontic Treatment Incurred while covered under the Policy if such services are included under the Policy.

A pre-determination for any Course of Treatment is not Treatment started. No benefits are payable if your Employer cancels the Policy and replaces it with another plan of group dental coverage within 30 days of the date the Policy ends.

What are Covered Dental Expenses?
The following is a list of those dental services which will be considered as Covered Dental Expenses. Covered Dental Expenses are based on current dental terminology which is updated from time to time. The most current terms may not be shown but benefits will be based on the most current dental terminology. Covered Dental Expenses must be Incurred while an Insured is covered under the Policy.

TYPE I DENTAL SERVICES
Oral Evaluations

Oral Evaluations are limited to 1 of these services in any 6 consecutive month period.

Bitewing X-rays
Bitewing X-rays are limited to 1 set (2 or 4 films) in any 12 consecutive month period.

Dental Prophylaxis
Dental Prophylaxis is limited to 1 time in any 6 consecutive month period. The number of Dental Prophylaxis and Periodontal Maintenance is combined and is limited to 4 in any 12 consecutive month period.

Genetic Test
A Genetic Test for susceptibility to oral diseases is limited to once per lifetime and to Insureds over age 18.

Fluoride Treatments
Fluoride Treatments are limited to 1 time in any 6 consecutive month period for Dependent Children under age 14.

Space Maintainers
Space Maintainers are limited to 1 per tooth in any 3 year period for Dependent Children under age 19 when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not, or will not develop. Benefits include all adjustments within 6 consecutive months of installation.

Sealants
Sealants are limited to 1 time per tooth in any 36 consecutive month period, to the occlusal surface of unrestored permanent first and second molars, and to Dependent Children under age 16.

TYPE II DENTAL SERVICES
There is a Benefit Waiting Period for Type II Covered Dental Expenses. The Benefit Waiting Period will not be applied if the Insured was enrolled in the Prior Plan.

6. COVERED DENTAL BENEFITS

Diagnostic Services
Accession and Examination of Tissue

Extraoral X-rays
Extraoral X-rays are limited to 1 film in any 6 consecutive month period.

Intraoral Periapical X-rays
Intraoral Periapical X-rays are limited to 4 films in any 12 consecutive month period.

Intraoral Occlusal X-rays
Intraoral Occlusal X-rays are limited to 2 films in any 12 consecutive month period.

Intraoral Complete Series
These x-rays are limited to 1 panorex or complete series in any 60 consecutive month period. Ten or more individual periapical x-rays and/or bitewing films or a panoramic film will be considered a complete series for benefit purposes.

Endodontic Services
Root Canal Therapy
Root Canal Therapy (including teeth treated prior to the Policy Effective Date) includes all pre-operative, operative, and post-operative x-rays; canal preparation and fitting of preformed dowel or post; bacteriologic cultures, diagnostic tests, local anesthesia, and routine follow-up care. Root Canal Therapy is limited to 1 time per tooth in any 24 consecutive month period.

Apicoectomy/Periradicular Surgery
Benefits for Apicoectomy/Periradicular Surgery include all pre-operative, operative, and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care.

Retrograde Filling
Retrograde Fillings are limited to 1 per root.

Hemisection
Benefits for Hemisection include any root removal, local anesthesia, and routine post-operative care. Benefits for root canal therapy are not included.

Pulpotomy
Pulpotomy is limited to Dependent Children under age 19.

Root Amputation

Non-surgical Periodontal Services

Scaling and Root Planing
Scaling and Root Planing is limited to 1 time per quadrant of the mouth in any 24 consecutive month period. It is not payable in addition to Dental Prophylaxis or Periodontal Maintenance performed on the same day.

Periodontal Maintenance following Active Periodontal Therapy
Periodontal Maintenance following active Periodontal Therapy is limited to 1 time in any 3 consecutive month period. The number of Periodontal Maintenance and Dental Prophylaxis is combined and is limited to 4 in any 12 consecutive month period.

Localized Delivery of Time Release Anti-microbial Agents into Diseased Crevicular Tissue
Localized delivery of time release anti-microbial agents into diseased crevicular tissue is limited to 1 time per tooth in any 12 consecutive month period.

Surgical Periodontal Services
Benefits for the following services are limited to only one of these procedures per quadrant, in any 36 consecutive month period.

Gingivectomy

Gingivoplasty

Osseous Surgery

Guided Tissue Regeneration

Osseous Graft
Osseous Graft is further limited to Treatment for periodontal disease. It is not covered when performed following an extraction at the same site.

Pedicle Graft

Tissue Grafts

Crown Lengthening

Distal or Proximal Wedge Procedure

Oral Surgery Services

Simple Extraction

Restorations

Amalgam Restorations
Amalgam Restorations are limited to one restoration per tooth in any 24 consecutive month period. Multiple restorations on one surface will be considered one restoration for benefit purposes. Restorations on 2 non-occlusal adjacent tooth surfaces will be considered 1 surface for benefit purposes.

Composite and Silicate Restorations
Composite and Silicate Restorations are limited to one restoration per tooth in any 24 consecutive month period. Restorations on 2 non-occlusal adjacent tooth surfaces will be considered 1 surface for benefit purposes.

Pin Retention
Pin Retention is limited to 1 time per restoration and is not covered in addition to cast restorations.

Other Type II Services
Consultation
These services are paid as a separate benefit only if performed by a Dentist who is not providing operative Treatment.

Therapeutic Drug Injections

Palliative Treatment
Palliative Treatment, including sedative fillings, are paid as a separate benefit only if no Treatment, except x-rays, was rendered during the visit.

TYPE III DENTAL SERVICES

6. COVERED DENTAL BENEFITS

There is a Benefit Waiting Period for Type III Covered Dental Expenses. The Benefit Waiting Period will not be applied if the Insured was enrolled in the Prior Plan.

Restorations

Inlays and Onlays
Inlays and Onlays are covered only if the tooth has extensive decay or fracture and cannot be restored by an amalgam or composite filling. Inlays and Onlays are limited to 1 per tooth in any 7 year period and to Insureds over age 16.

Crown Buildup
A Crown Buildup, including pins and pre-fabricated posts will be paid as a separate procedure only when required for placement of a crown if that crown is a Covered Expense and is limited to 1 per tooth in any 7 year period.

Crowns
Crowns, including Porcelain Crowns on anterior teeth, are covered only if the tooth has extensive decay or fracture and cannot be restored by an amalgam or composite filling. Benefits include temporary restorations and follow-up care within 12 months of insertion. Crowns are limited to 1 per tooth in any 7 year period and to Insureds over age 16.

Veneers
Veneers are limited to anterior teeth and covered only if the tooth cannot be restored by a filling or by other means. Veneers are limited to 1 per tooth in any 7 year period and to Insureds over age 16.

Post and Core
Post and Core is covered only for a tooth treated by a root canal that requires a crown. Post and Core is limited to 1 per tooth in any 7 year period.

Stainless Steel Crowns
Stainless Steel Crowns are covered only if the tooth cannot be restored by an amalgam or composite filling and are limited to 1 time in any 36 consecutive month period and to Dependent Children under age 19.

Prosthodontics
Removable Full Dentures
Benefits for Removable Full Dentures include temporary restorations, appliances, and follow-up care within 12 months of insertion. Benefits for personalized dentures, overdentures or associated Treatment will be considered a part of the final dental service. Replacement of Removable Full Dentures is limited to 1 per arch in any 7 year period and only if the Denture cannot be made serviceable.

Removable Partial Dentures
Benefits for Removable Partial Dentures include all temporary restorations, clasps, rests, teeth, and follow-up care within 12 months of insertion. Replacement of Removable Partial Dentures is limited to 1 per arch in any 7 year period and only if the Denture cannot be made serviceable.

Clasps and Rests
Benefits for additional Clasps and Rests are provided after 12 months of insertion.

Relining Dentures, Rebasing Dentures
Relining or Rebasing Dentures are considered part of the denture charges if services are provided by the same Dentist and are within 12 months of insertion. Subsequent relining or rebasing is limited to 1 time in any 36 consecutive month period.

Denture Adjustments
Denture Adjustments are considered part of the denture charges if services are provided by the same Dentist and are within 12 months of insertion. Subsequent adjustments are limited to 1 time in any 12 consecutive month period.

Tissue Conditioning
Tissue Conditioning is limited to services performed after 12 months of the insertion of the Denture.

Fixed Bridges
Benefits for Fixed Bridges are limited to Insureds over age 16 and include temporary restorations, appliances, and follow-up care within 12 months of insertion. Unless there was a Dentally Necessary extraction of an additional Functioning Natural Tooth and that tooth was not an abutment to an existing bridge, replacement of Fixed Bridges is limited to 1 per arch in any 7 year period and only if the Bridge cannot be made serviceable.

Oral Surgery Services

Surgical Extraction of Erupted Teeth, Impacted Teeth, or Exposed Root
Multiple surgical services on one area of the mouth will be based on the most inclusive procedure and includes local anesthesia and routine post-operative care.

Alveoplasty
Multiple surgical services on one area of the mouth will be based on the most inclusive procedure and includes local anesthesia and routine post-operative care.

Vestibuloplasty
Multiple surgical services on one area of the mouth will be based on the most inclusive procedure and includes local anesthesia and routine post-operative care.

Removal of Lateral Exostosis
Multiple surgical services on one area of the mouth will be based on the most inclusive procedure and includes local anesthesia and routine post-operative care.

Frenectomy
Multiple surgical services on one area of the mouth will be based on the most inclusive procedure and includes local anesthesia and routine post-operative care.

Excision of Hyperplastic Tissue
Excision of Hyperplastic Tissue is limited to 1 time per arch. Multiple surgical services on one area of the mouth will be based on the most inclusive procedure and includes local anesthesia and routine post-operative care.

Orantral Fistula Closure
Multiple surgical services on one area of the mouth will be based on the most inclusive procedure and includes local anesthesia and routine post-operative care.

Biopsy

Incision and Drainage
Incision and Drainage is not covered as a separate expense when performed with a single extraction.

Tooth Re-implantation or Stabilization

General Anesthesia and IV Sedation
General Anesthesia and IV Sedation are limited to three 15 minute units. Benefits for General Anesthesia are limited to the benefit for IV sedation. Benefits for General Anesthesia and IV Sedation are payable as a separate expense only when required for the surgical extraction of an impacted tooth.

Other Type III Services

Repair/Recement Full Dentures, Partial Dentures, Crowns, Inlays
Repairs to, or recementing of, Full Dentures, Partial Dentures, Crowns, or Inlays are covered 12 months after insertion.

Occlusal Guard
Occlusal Guards are covered only for the Treatment of bruxism or grinding.

7. EXCLUSIONS

What exclusions apply to the benefits payable?
Covered Dental Expenses do not include and no benefits are provided for:

- procedures which are not included in the list shown in the “Covered Dental Benefits: What are Covered Dental Expenses?” section.
- dental care which is not customarily performed or which is experimental in nature. By experimental, we mean: the use of any Treatment, procedure, facility, equipment, drug, or drug usage device or supply which we determine is not acceptable standard dental Treatment of the condition being treated. Any such items requiring federal or other governmental agency approval which was not granted at the time the services were rendered will also be considered experimental. In making the determination as to whether dental care is experimental, we will rely on the advice of the general dental community including, but not limited to dental consultants and dental journals and/or regulations.
- charges for oral hygiene instruction, a plaque control program, tobacco counseling, dietary instruction or other educational services.
- charges for house or hospital calls for dental services and for hospitalization costs (e.g. facility-use fees).
- charges for prescription and non-prescription drugs, vitamins or dietary supplements.
- charges for medical exams prior to oral surgery.
- charges for procedures that are:
  - part of a service but are reported as separate services;
  - reported in a Treatment sequence that is not appropriate; or
  - misreported or that represent a procedure other than the one reported.
- charges made by a Dentist, Dental Hygienist, or Denturist who:
  - normally lives in the Insured's home, unless a Family Member;
  - is an employee of the Policyholder; or
  - is a Policyholder.
- charges for Treatment that is not Dentally Necessary or not deemed to be within generally accepted standards of dental Treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the determination will be made by us.
- charges for completion of claim forms or failure to keep appointments.
- charges for any of the following:
  - dental care resulting from war or an act of war, or any involvement in any period of any type of armed conflict (this does not include acts of terrorism);
  - active participation in a war (declared or undeclared);
  - active military duty;
  - dental care resulting from any injury which is self-inflicted or not caused by an accident;
  - dental care resulting from active Participation in a Riot; Rebellion, or Insurrection;
  - dental care resulting from the commission or attempted commission of an assault, felony or other criminal act.
- 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, or for which the Insured is entitled to payment under an automobile insurance policy. Benefits paid by us would be in excess to the third-party benefits and therefore, we would have the right of recovery for any benefits paid in excess.
- Covered Dental Expenses Incurred while insurance is not in force under the Policy.
- charges for incomplete Treatment (e.g. patient does not return to complete Treatment) and charges for temporary services (e.g. temporary restorations).
- charges for care, Treatment, services, or supplies to the extent that any benefit is provided by Medicare.
- charges which are not customarily made when there is no insurance, or charges for which there is no legal obligation to pay.
- charges for Treatment performed outside the United States except for a Maximum Benefit of $100 for emergency dental Treatment performed outside the United States.
- procedures which are elective.

7. EXCLUSIONS

- procedures that we determine are cosmetic in nature.
- replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.
- implants; implant abutments; implant supported crowns, bridges or dentures; or any other service for the care and Treatment of an implant.
- specialized procedures and techniques (e.g. precision or semi-precision attachments, copings, over dentures or customized prostheses or attachments).
- a fixed bridge that replaces the extracted portion of a hemisected tooth.
- duplicate dentures, prosthetic devices or any other duplicative device.
- charges for bridges, partial or full dentures, inlays, onlays, crowns, implant crowns and other laboratory prepared restorations if they can, as determined by us, be satisfactorily restored with an amalgam or composite filling.
- the initial placement of bridges, or partial or full dentures to replace teeth missing on the effective date of the Insured's coverage under the Policy, including congenitally missing teeth. Benefits will be payable for Covered Dental Expenses for bridges, or dentures if the prosthesis includes the initial replacement of a Functioning Natural Tooth that is extracted by a Dentist while the Insured is covered under the Policy except that the replacement of:
  - an extracted tooth will not be considered a Covered Dental Expense if it was an abutment to an existing prosthesis;
  - those teeth extracted while an Insured is covered under the Policy will be considered a Covered Dental Expense; and
  - teeth missing on an Insured’s effective date will not be considered a Covered Dental Expense.

  Benefits will be payable for Covered Dental Expenses for bridges, or partial or full dentures, to replace a tooth that was extracted while the Insured was covered under the Prior Plan. Such extraction must have occurred within the preceding 12 months and have been a covered expense under the Prior Plan. No benefits will be payable for any expenses that are payable under the Prior Plan's extension of benefits provision.
- charges for replacement of bridges, partial or full dentures, inlays, onlays, crowns, implant crowns and other laboratory prepared restorations if they can, as determined by us, be satisfactorily repaired and restored to function.
- charges for pulp caps.
- charges for diagnostic casts.
- charges for Treatment of fractures and dislocations of the jaw.
- charges for Treatment of malignancies or neoplasms.
- charges for desensitizing medications.
- administration of nitrous oxide or other agent to control anxiety.
- charges for occlusal adjustments.
- charges for periodontal splinting of teeth by any method.
- charges for orthodontic Treatment.
- charges for retention of orthodontic relationships.
- charges for Treatment or appliances whose primary purpose is to:
  - change or maintain vertical dimension;
  - alteration or restoration of occlusion, except for occlusal adjustment in conjunction with periodontal surgery;
  - bite registration, or bite analysis;
  - treat attrition or abrasion.
- charges for diagnostic services and Treatment of jaw joint problems by any method. Examples of these jaw joint problems are temporomandibular joint disorders or other conditions of the joint linking the jaw bone and the complex muscles, nerves and other tissues related to the joint.
- charges for any Treatment of congenital mouth malformations or skeletal imbalances (e.g. Treatment related to cleft lip or cleft palate, disharmony of facial bone or required as the result of orthognathic surgery including Orthodontic Treatment).

8. CLAIM PROVISIONS

How is a claim submitted?
To submit a claim, you or someone on your behalf must send us Written notice and proof of claim within the time limits specified. Your Employer has the notice and proof of claim forms.

NOTICE OF CLAIM

When does Written notice of claim have to be submitted?
Written notice of claim must be given to us no later than 90 days after the date the expense is Incurred. If notice cannot be given within the applicable time period, we must be notified as soon as it is reasonably possible.

When we receive Written notice of claim, we will send the forms for proof of claim. If the forms are not received within 15 days after Written notice of claim is sent, proof of claim may be sent to us without waiting to receive the proof of claim forms.

PROOF OF CLAIM

When does Written proof of claim have to be submitted?
Written proof of claim must be given to us no later than 90 days after the date the expense is Incurred.

If proof cannot be given within the time limit, proof must be given as soon as reasonably possible. Proof of claim may not be given later than one year after the time proof is otherwise required unless you are legally incompetent.

What is considered proof of claim?
Proof of claim is any information that we may reasonably require to verify the eligibility or insurability of any Insured. We may require any of the following:

- a complete dental chart showing:
  - extractions;
  - missing teeth;
  - fillings;
  - prostheses;
  - periodontal pocket depths; and
  - the date of any work previously performed.
- an itemized bill for all dental care.
- the following exhibits:
  - x-rays;
  - study models;
  - laboratory and/or hospital records.
- a dental examination at our expense by a Dentist whom we choose.
- any other information we may require to make a claim determination.

We may require as part of the proof, authorizations to obtain dental and non-dental information. Proof must be satisfactory to us.

PAYMENT OF BENEFITS

When will a decision on your claim be made?
We will send you a Written notice of our decision on your claim within a reasonable time after we receive the claim but not later than 30 days after receipt of your proof of claim. If we cannot make a decision within 30 days after receiving your claim, we will request a 15 day extension as permitted by U.S. Department of Labor regulations. Any request for extension will specifically explain:

- the standards on which entitlement to benefits is based;
- the unresolved issues that prevent a decision on the claim; and
- the additional information needed to resolve those issues.

If a period of time is extended because you failed to provide necessary information, the period for making the benefit determination is tolled from the date we send notice of the extension to you until the date on which you respond to the request for additional information. You will have 45 days to provide the specified information.

When are benefits payable?
Benefits are payable upon our receipt of satisfactory proof of claim that establishes benefit eligibility according to the provisions of the Policy.

What if your claim is denied?
If we deny all or any part of your claim, you will receive a Written notice of denial setting forth:

- the specific reasons for the denial;
- the specific Policy provisions on which the denial is based;
- your right to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits;
- a description of any additional material or information needed to prove entitlement to benefits and an explanation of why such material or information is necessary;
- a description of the appeal procedures and time limits;
- your right to bring a civil action under ERISA, §502(a) following an adverse determination on review; and
- the identity of an internal rule, guideline, protocol or other similar criterion, if any, that was relied upon to deny the claim and a copy of the rule, guideline, protocol or criterion or a statement that a copy is available free of charge upon request.

Can you request a review of a claim denial?
You may request a review of the denial in accordance with the Group Dental Appeals Process Information Packet located at the end of the Certificate.

You may submit Written comments, documents, records or other information relating to your claim for benefits, and may request free of charge copies of all documents, records, and other information relevant to your claim for benefits.

We will review the claim on receipt of the Written request for review, and will notify you of our decision within a reasonable time but not later than 30 days after receiving all necessary information. If an extension of time is required to review your request, we will notify you in Writing of the special circumstances requiring the extension and the date by which we expect to make a determination on the review. The extension cannot exceed a period of 30 days from the end of the initial period.

If a period of time is extended because you failed to provide information necessary to decide your claim, the period for making the decision on review is tolled from the date we send notice of the extension to you until the date on which you respond to the request for additional information. You will have at least 45 days to provide the specified information.

What if your claim is denied on review?
If we deny all or any part of your claim on review, you will receive a Written notice of denial setting forth:

- the specific reasons for the denial;
- the specific Policy provisions on which the denial is based;
- your right to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits;
- your right to bring a civil action under ERISA, §502(a);
- the identity of an internal rule, guideline, protocol or other similar criterion, if any, that was relied upon to deny the claim and a copy of the rule, guideline, protocol or criterion or a statement that a copy is available free of charge upon request;

- the following statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State Insurance regulatory agency.”; and
- the identity of any dental experts whose advice was obtained in connection with the appeal, regardless of whether the advice was relied upon to deny the appeal.

Are you eligible for an external review of your claim denial?
If all or part of your claim is denied on review, you may request, in Writing, an external review of the denial in accordance with the Group Dental Appeals Process Information Packet located at the end of the Certificate.

To whom are benefits payable?
We will pay you if your proof of claim is satisfactory to us except in the following situations:
- An Insured assigns benefits to a provider. In such case, we may pay the benefits directly to the provider.
- 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.
- 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 above.
- 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.

COORDINATION OF BENEFITS

What is Coordination of Benefits?
If an Insured is covered under more than one dental plan, the benefits from other Plans will be taken into account. This may require a reduction in benefits under the Policy, so that the combined benefits will not be more than the Allowable Expenses of the Policy and any other Plan.

What is a Plan?
For purpose of Coordination of Benefits (COB), a Plan is any plan that provides dental expense benefits or services under:
- group insurance, individual insurance or any other insured or uninsured arrangement of coverage; or
- basic automobile reparations (no-fault) insurance, but only:
  - to the extent of the benefits required by or available under the applicable no-fault law; and
  - 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:
- separately with respect to each policy, contract, or other arrangement for benefits or services; and
- separately with respect to each of the following:
  - 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
  - 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.

What is an Allowable Expense?
For purpose of COB, an Allowable Expense is any necessary, reasonable, and customary item of Covered Dental Expense (as shown in the “What are Covered Dental Expenses?” section) that is at least partly covered under at least one of the Plans covering the Insured for whom claim is made. When a Plan provides benefits in the form of services rather than cash, the value of each service will be considered to be both an Allowable Expense and a benefit paid.

How are benefits computed under COB?
In a Benefit Year, the Policy 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 Insured for whom claim is being made.

Are there any limits on the use of COB?
In computing the benefits under the Policy, the benefits under any other Plan will not be included if:

- the other Plan contains a COB provision that:
  - provides for coordinating its benefits with those of the Policy; and
  - under its terms, would compute its benefits after we compute the benefits under the Policy; and
- the rules shown in the "How are plans' benefits determined" section require that the Policy's benefits are computed before the other Plan computes its benefits.

How are plans' benefits determined?
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:

- a Plan with no COB provision will be considered to pay its benefits before a Plan that contains such a provision.
- 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.
- 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, divorced, or not living together, whether or not they have ever been married, the following rules apply:
  - 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
  - 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.
  - if the parent with custody of the child has 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 that child as a dependent of the step-parent; and
    - 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.
- Where the rules 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 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. If the other Plan does not contain this rule, then this rule shall not apply.

What are 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.

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.

8. CLAIM PROVISIONS

Any person who claims benefits under the Policy 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 the Policy will be deemed to have authorized us to secure the information necessary to apply the terms of this provision.

What if a Plan makes a payment that should have been made by us?
If any payment that should have been made under the Policy 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:

- be deemed a benefit paid under the Policy; and
- fully discharge us from our liability under the Policy.

What if we overpay a claim?
If a payment made under the Policy 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:

- any person to whom, for whom, or with respect to whom such payment is made;
- any other insurance company; or
- any other organization.

9. INSURANCE CONTINUATION

Are there any conditions under which your Employer can continue your insurance?
While the Policy is in force and subject to the conditions stated in the Policy, your Employer may continue your insurance that was in force on the date immediately before the date you ceased to be Actively at Work by paying the required premium to us for any of the following reasons and durations:

- Absence due to injury or sickness – up to 12 months;
- Layoff – up to 3 months;
- Leave of Absence (including Family and Medical Leave of Absences) – up to 3 months;
- Vacation – based on your Employer's policy, not to exceed 3 months.

While the Policy is in force, you may be eligible to continue your insurance as long as your Employer keeps paying premiums on your behalf. You should contact your Employer for more details.

While the Policy is in force, you may be eligible to continue your insurance pursuant to the Family and Medical Leave Act of 1993, as amended or continue coverage pursuant to a state required continuation period (if any). You should contact your Employer for more details.

While the Policy is in force, you may be eligible to continue your insurance coverage pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA). You should contact your Employer for more details.

Are there any conditions under which you can continue your insurance?
Federal law requires certain employers to offer continuation coverage to Employees for a specified period of time upon termination of employment or reduction of work hours for any reason other than gross misconduct. You should contact your Employer to find out whether or not this requirement applies. Your Employer will advise you of your rights to continuation coverage, if any, and the cost.

If this requirement does apply, you must elect to continue coverage within 60 days from your Family Status Change or notification of rights by your Employer, whichever is later.

You may elect to extend coverage for your eligible Dependents, or your eligible Dependents may elect to continue coverage under certain circumstances or due to a Family Status Change. Dependents must elect to continue coverage within 60 days from the event or notification of rights by your Employer, whichever is later.

You must pay the required premium for continuation coverage directly to your Employer. We are not responsible for determining who is eligible for continuation coverage. If the Policy contains a continuance provision that is mandated by a state law, Insureds eligible under that provision will have the choice of electing:

- the state continuance coverage and then the federal continuance coverage, if allowed by state law; or
- the federal continuance alone.

10. CONTINUITY OF COVERAGE

What happens if your Employer replaces other dental coverage with this Certificate and the Policy?
If an Insured was covered under the Prior Plan, the Continuity of Coverage benefits set forth in this Section may be available.

What if you are not Actively at Work when your Employer replaces the Prior Plan with the Policy?
You and your Dependents will be insured under the Policy if you are not Actively at Work on October 1, 2019 if:

- you were insured under the Prior Plan on the day before October 1, 2019;
- you are a member of an Eligible Class; and
- your Employer continues to remit premiums for your coverage.

What if your Spouse or Dependent Child is Confined when your Employer's Prior Plan is replaced with the Policy and you are Actively at Work?
Your Spouse or Dependent Child will be insured under the Policy on October 1, 2019 if:

- your Spouse or Dependent Child was insured under your Employer's Prior Plan on the day before October 1, 2019;
- you are a member of an Eligible Class for Spouse or Dependent Child coverage; and
- you or your Employer continue to remit premiums for your Spouse or Dependent Child coverage.

Do any waiting periods apply when your Employer's Prior Plan is replaced with the Policy?
We will apply any period of time satisfied under the Prior Plan to meet the requirements of the Eligibility Waiting Period toward the satisfaction of the period of time required by the Policy's Eligibility Waiting Period.

If an Insured was eligible for coverage but not covered under the Prior Plan on the day before the Effective Date of the Policy, the Late Entrant Benefit Waiting Period will apply.

Are benefits payable for Treatment you started before the Effective Date of the Policy?
If an Insured Incurs Covered Dental Expenses for a Course of Treatment that is started while covered under the Prior Plan and is completed while covered under the Policy, benefits for that Insured may be payable under the terms of the Policy except that:

- no benefits will be payable for any expenses that are payable under the Prior Plan's extension of benefits provision;
- benefits will be payable for only those Covered Dental Expenses Incurred during that portion of the Course of Treatment that the Insured received while they were insured under the Policy; and
- if the Prior Plan had no extension of benefits provision, benefits under the Policy will be based on the percentage of Treatment performed while covered under the Prior Plan.

The Maximum Benefit and any other limits on amounts or time limitations on benefits payable under the Policy 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.

What happens to your Deductible and Maximum Benefit if you were covered under the Prior Plan?
For the Benefit Year in which the Policy becomes effective, we will reduce an Insured's Deductible and Maximum Benefit under the Policy by any amount of Covered Dental Expenses that are Incurred in the Benefit Year in which the Policy becomes effective and applied toward the Prior Plan's deductible for such year.

An Insured's Deductible under the Policy 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 from the Maximum Benefit of the Policy.

10. CONTINUITY OF COVERAGE

What happens to your Maximum Benefit Rollover if you were covered under the Prior Plan?

If the Prior Plan included a Maximum Benefit Rollover, an Insured may receive a credit of the lessor of:

- the amount of their Prior Plan's rollover account balance; or
- this plan's Account Maximum.

An Insured's Account cannot be credited unless we receive the rollover account balance information of the Prior Plan.

11. GENERAL PROVISIONS

AGENCY

Can the Policyholder, Employer or third party administrator act as our agent?
For all purposes of the Policy, the Policyholder, Employer or third party administrator acts on its own behalf or as your agent. Under no circumstances will the Policyholder, Employer or third party administrator be deemed an agent of Sun Life Assurance Company of Canada.

ALTERATION

Who can alter this Certificate?
The only persons with the authority to alter or modify this Certificate or to waive any of its provisions are our president, actuary, secretary or one of our vice presidents and any such changes must be in Writing.

ASSIGNMENT

Can benefits be assigned?
You can assign benefits to a provider. You cannot assign any other 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. 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.

CLERICAL ERROR

What happens when there is a clerical error in the administration of the Policy?
Clerical errors in connection with the Policy or delays in keeping records for the Policy whether by us, the Policyholder, the Employer or third party administrator:

- will not terminate insurance that would otherwise have been effective; and
- 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.

This provision does not apply to benefit administration errors by the Policyholder or the Employer which results in an Employee:

- not enrolling for insurance within required time limits; or
- failing to exercise any available continuation options.

CONFORMITY WITH STATUTES

What is the effect of Conformity with Statutes?
If any provision of the Policy conflicts with any applicable law, the provisions of the Policy will be automatically amended to meet the minimum requirements of the law except as otherwise pre-empted by federal law.

DISCHARGE OF OUR RESPONSIBILITY

What is the effect of payments under the Policy?
Payment made under the terms 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.

11. GENERAL PROVISIONS

INCONTESTABILITY

What is the Incontestability Provision?
Except for non-payment of premium, fraud or any claims incurred within two years of the effective date of an Insured's initial, increased, additional or reinstated insurance, no statement made by any Insured relating to insurability for such insurance will be used to contest the validity of that insurance after the insurance has been in force for a period of two years during that individual's lifetime. The statement must be contained in a form Signed by that individual.

This provision shall not preclude the assertion at any time of a defense to a claim based upon the Insured's eligibility for insurance.

INSURER'S AUTHORITY

What is our authority?
We have discretionary authority to make all final determinations regarding claims for benefits under the Policy. This discretionary authority includes, but is not limited to, the right to determine eligibility for benefits, based upon enrollment information provided by the Policyholder, and the amount of any benefits due, and to construe the terms of the Policy.

Any decision made by us in the exercise of this authority, including review of denials of benefit, is conclusive and binding on all parties. Any court reviewing our determinations shall uphold such determination unless the claimant proves that our determinations are arbitrary and capricious.

LEGAL PROCEEDINGS

What are the time limits for legal proceedings?
No legal action may start:

- until 60 days after proof has been given; nor
- more than 3 years after the time proof of claim is required.

LIMIT OF PREMIUM REFUNDS

Is there a limit on 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.

MISSTATEMENT OF FACTS

What happens if there is a misstatement of facts in the administration of the Policy?
If relevant facts about the Employer or Employee relating to this insurance are determined not to be accurate:

- a fair adjustment of premium will be made, subject to the "Limit of Premium Refunds" section; and
- the actual facts will decide whether, and in what amount, and for what duration insurance is valid under the Policy.

NON-PARTICIPATING

Does the Policy participate in dividends?
The Policy is non-participating and will not share in any profits or surplus earnings of Sun Life Assurance Company of Canada, and, therefore, no dividends are payable.

11. GENERAL PROVISIONS

PREMIUM PAYMENTS AS EVIDENCE OF INSURANCE

Does the payment of premiums guarantee coverage under the Policy?
The receipt of premiums by us is not a guarantee of insurance. Eligibility for benefits will be determined at the time of claim submission and in order to receive a benefit under the Policy, all Policy requirements must be satisfied. If we determine that you or your Dependents are not eligible for coverage, you should contact the Policyholder, the Employer or third party administrator regarding the refund of premiums due, if any.

REIMBURSEMENT

What if a benefit is underpaid or overpaid?
Reimbursement will be made to us for any overpayments that we may make due to any reason. You must repay us within 60 days unless we agree to a longer time period. Deductions may be made from future benefit payments to recover any such overpayments.

If we have underpaid a benefit for any reason, we will make a lump sum payment for that amount.

Interest does not accrue on any underpaid or overpaid benefit unless required under the applicable law.

STATEMENTS

Are statements warranties?
In the absence of fraud, all statements made in any application are considered representations and not warranties. No representation by you in enrolling for insurance under the Policy will be used to reduce or deny a claim unless it is contained in your Written application, Signed by you, and a copy of your Written application for insurance is or has been given to you, your beneficiary, if any, or to your estate representative.

TIME PERIODS

What time periods apply to this Certificate?
For the purpose of effective dates and termination dates under this Certificate, all days begin at 12:00 midnight and end at 11:59:59 PM at the Policyholder’s location.

SUN LIFE ASSURANCE COMPANY OF CANADA
CERTIFICATE ENDORSEMENT

This endorsement is part of the Certificate to which it attaches and is effective on 932864-001 and is effective on October 1, 2019. It is part of, and subject to, the other terms and conditions of the Certificate. If the terms of this endorsement and the Certificate conflict, then this endorsement's provisions will control.

With respect to this Certificate Endorsement, only, the following definition applies:

Prior Policy means the Dental policy issued to the Policyholder by Union Security Insurance Company that was in effect immediately prior to this Policy.

The following provisions apply to any Insured who was covered under the Prior Policy on the day before the effective date of Policy:

- Any representation made for the purposes of obtaining or continuing insurance under the Prior Policy shall be deemed to have been made also for the purposes of obtaining insurance under this Policy. However, for the sole purpose of applying the section entitled INCONTESTABILITY, the effective date of an Employee's or Dependent's coverage under the Prior Policy shall be deemed the effective date of the Employee's or Dependent's coverage under the Policy.
- For the purposes of determining any waiting period (by whatever name called) before insurance becomes effective or benefits become payable under this Policy, credit will be given for the completion or partial completion of any waiting period under the Prior Policy.
- For the purposes of determining any coinsurance or cash deductible provisions under this Policy, credit will be given for any coinsurance and/or cash deductible provisions satisfied or partially satisfied under the Prior Policy.
- For the purposes of determining any benefit maximum, duration or limitation of benefits under this Policy, all benefits paid under the Prior Policy with respect to any person shall be deemed to have been paid as benefits under this Policy with respect to said person. All periods of time with respect to which benefits were paid under the Prior Policy shall be deemed to be periods of time with respect to which benefits were paid under this Policy.
- Any request, election or assignment made under the Prior Policy, shall be deemed to have been made under this Policy as of the time originally made under the Prior Policy.
- Any uninterrupted period of time during which insurance was in force under the Prior Policy with respect to any person, shall be deemed included in the period of time insurance for said person was in effect without interruption under this Policy.
- Any reference to Employee or Dependents in this Policy will be deemed to include any insured regardless of what they are called in the Prior Policy.
- In no event will any benefit be payable under this Policy which duplicates any benefit payable under the Prior Policy.

In the event of a conflict between the Policy and the Prior Policy, the terms of the Policy will control.

Kevin Strain
President and Chief Executive Officer

SUN LIFE ASSURANCE COMPANY OF CANADA

Group Dental Certificate

Non-Participating

Earnhardt Management Company Employee Benefit Plan (The Plan) has been established to provide welfare benefits for its employees.

The Employee Retirement Income Security Act of 1974 (ERISA) requires that the Plan Administrator provide you with a Summary Plan Description which discloses required information about the employee benefit plan. The following section entitled "Summary Plan Description" is not part of the Group Insurance Policy. The information in the Summary Plan Description is provided by the Policyholder and is included in this Certificate for your convenience. Sun Life Assurance Company of Canada assumes no responsibility for the accuracy or sufficiency of the information in the Summary Plan Description.

SUMMARY PLAN DESCRIPTION

Plan Sponsor: Earnhardt Management Company
7300 W Orchid Ln
Chandler, AZ 85226

Plan Administrator: Earnhardt Management Company
7300 W Orchid Ln
Chandler, AZ 85226

The Plan Administrator has authority to control and manage the operation and administration of the Plan.

Subsidiaries/Affiliates: Earnhardt Chrysler Dodge Jeep Ramarnhardt Ford; Earnhardt Honda; Earnhardt Toyota Scion; Earnhardt Buick GMC; Rodeo Ford; Earnhardt Kia; Earnhardt Hyundai, Avondale; Hyundai; Earnhardt Hyundai, North; Scottsdale; Earnhardt Scottsdale Lexus;

Agent for Service of Legal Process: Earnhardt Management Company
7300 W Orchid Ln
Chandler, AZ 85226

Employer Identification Number (EIN): 86-0394615

Plan Number: 501

End of Plan Year: September 30th

Type of Administration: The Plan is administered by the Plan Administrator. The benefits provided by the Group Insurance Policy issued by Sun Life Assurance Company of Canada are included in the Plan.

Participants: The insured employees described in Sun Life Assurance Company of Canada Certificate.

Plan Changes and Termination: The Plan Administrator may amend, modify or terminate the Plan.

Contributions: The cost of your benefits under the Plan is paid for by your employer and (if applicable) includes the cost of any insurance premiums contributed by you.

Funding: Sun Life provides the Plan Administrator with certain insurance benefits in connection with the Plan. Those insurance benefits are described in your Certificate.

Claims Procedure: When you or your beneficiary wish to file a claim under the Plan, you should contact your personnel office for claim forms and instructions for filing. Your Certificate explains the procedure for filing a claim under the Group Insurance Policy.

If your claim for benefits is denied in whole or in part, you will receive a written notice within the time required by ERISA from the date you filed your claim, stating the reasons why your claim was denied. You will then have the right, upon written notice from you or your authorized representative, to review that claim denial. The claim denial notice will include the name and address of the person you may ask for such a review. Additional information about claims submitted and review procedures may be obtained by contacting your Plan Administrator.

Your Rights under ERISA:

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan Documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance of the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits

Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Group Dental Appeals Process Information Packet

Group Dental Appeals Process Information Packet
Sun Life Assurance Company of Canada

CAREFULLY READ THE INFORMATION IN THIS PACKET AND KEEP IT FOR FUTURE REFERENCE. IT HAS IMPORTANT INFORMATION ABOUT HOW TO APPEAL DECISIONS THAT WE MAKE ABOUT YOUR DENTAL CARE.

Getting Information About the Dental Care Appeals Process Help in Filing an Appeal: Standardized Forms and Consumer Assistance From the Department of Insurance

We will send you a copy of this information packet when you first receive your policy, and within 5 business days after we receive your request for an appeal. When your insurance coverage is renewed, we will also send you a separate statement to remind you that you can request another copy of this packet. We will also send a copy of this packet to you or your treating provider at any time upon request. Just call our dental claims toll-free number 800.442.7742 to ask for a copy.

At the back of this packet, you will find a form that you can use for your appeal. The Arizona Department of Insurance and Financial Institutions ("Department") developed these forms to help people who want to file a dental care appeal. You are not required to use them. We cannot reject your appeal if you do not use them. If you need help in filing an appeal, or you have questions about the appeals process, you may call the Department's Consumer Assistance Office at 602.364.2499 or 800.325.2548 or call us at our toll-free number 800.442.7742.

How to Know When You Can Appeal

When we deny all or a portion of a dental claim, we will notify you of your right to appeal that decision. Your notice may come directly from us or through your treating provider.

Decisions You Can Appeal

You can appeal the following decisions:

1. We do not pay for a service that you have already received.
2. We deny all or a portion of a dental claim because we determined that an alternate treatment would accomplish a professionally satisfactory result.
3. We deny all or a portion of a dental claim because we determine that it is not covered under your insurance policy, and you believe it is covered.

Decisions You Cannot Appeal

You cannot appeal the following decisions:

1. You disagree with our decisions as to the amount of "usual and customary charges."
2. You disagree with how we are coordinating benefits when you have dental insurance with more than one insurer.
3. You disagree with how we have applied your claims or services to your dental plan deductible.
4. You disagree with the amount of coinsurance or copayments that you have paid.
5. You disagree with our decision to issue or not issue a dental policy to you.
6. You are dissatisfied with any rate increase you may receive under your dental insurance policy.
7. You believe that we have violated any other parts of the Arizona Insurance Code.

If you disagree with a decision that is not appealable according to this list, you may still file a complaint with the Arizona Department of Insurance and Financial Institutions, Consumer Affairs Division, 100 N. 15th Avenue, Suite 261, Phoenix, AZ 85007-2630.

Who Can File an Appeal?

Either you or your treating dental provider can file an appeal on your behalf. At the end of this packet is a form that you may use for filing your appeal. You are not required to use this form, and can send us a letter with the same information.

Description of the Dental Appeals Process

The dental appeals process has two levels of appeals.

Level 1 Formal Appeal
Level 2 External Independent Dental Review

We make the decisions at Level 1. An outside reviewer, who is completely independent from our company, makes Level 2 decisions. You are not responsible to pay the costs of the external review if you choose to appeal to Level 2.

APPEALS PROCESS FOR DENIED DENTAL CLAIMS

Level 1: Formal appeal

Your request*:* You may request Formal Appeal if: (1) you have dental coverage with us, and (2) we deny all or a portion of a dental claim. You have 2 years from our first denial notice to request Formal Appeal. To help us make a decision on your appeal, you or your provider should also send us information (that you have not already sent us) to show why we should pay the claim. Send your appeal request and information to:

Sun Life Assurance Company of Canada
PO Box 2940
Clinton, IA 52733-2940
800.442.7742

Our acknowledgement: We have 5 business days after we receive your request for Formal Appeal ("the receipt date") to send you and your treating dental provider a notice that we got your request.

Our decision: We have up to 60 days to decide whether we should change our decision and pay your claim. We will send you and your treating dental provider our decision in writing. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny all or a portion of your dental claim: You have 4 months to appeal to Level 2.

If we grant your request: We will pay the claim and the appeal is over.

If we refer your case to Level 2: We may decide to skip Level 1 and send your case straight to an independent reviewer at Level 2.

Level 2: External, Independent Review

Your request: You may appeal to Level 2 only after you have appealed through Level 1. You have 4 months after you receive our Level 1 decision to send us your written request for External Independent Review. Send your request and any more supporting information to:

Sun Life Assurance Company of Canada
PO Box 2940
Clinton, IA 52733-2940
800.442.7742

Neither you nor your treating dental provider is responsible for the cost of any external independent review.

The process: If we deny all or part of your claim for dental services, the denial will be due to contract coverage. This means that the denial is made because we determine that a service is not covered under your insurance policy or because an alternate treatment would accomplish a professionally satisfactory result. For denials based on contract coverage, the Arizona Department of Insurance and Financial Institutions is the independent reviewer.

Contract Coverage Cases

Within 5 days after receiving your request, we will:

1. Mail a written acknowledgement of your request to the Insurance Director, you and your treating dental provider.

2. Send the Director of Insurance: the request for review, your policy, evidence of coverage or similar document; all dental records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and any clinical reason of our decision.

Within 15 days of receiving this information, the Insurance Director must determine if the dental claim is payable, issue a decision, and send a notice to us, you, and your treating dental provider.

Referral to the Independent Review Organization ("IRO") for contract coverage cases: The Insurance Director is sometimes unable to determine issues of coverage. If this occurs, the Insurance Director will forward your case to an IRO. The IRO will have 21 days to make a decision and send it to the Insurance Director. The Insurance Director will have 5 business days after receiving the IRO's decision to send the decision to you, your treating dental provider, and us. If the IRO has decided that the claim is payable, we will issue payment. If the IRO agrees with our decision to uphold the denial, the appeal is over.

The decision (contract coverage): If you disagree with the Insurance Director's final decision on a coverage issue, you may request a hearing with OAH. If we disagree with the Director's determination of coverage issues, we may also request a hearing at OAH. Hearings must be requested within 30 days of receiving the coverage issue determination. OAH has rules that govern the conduct of their hearing proceedings.

Obtaining Dental Records

Arizona law (A.R.S. §20-2293) permits you to ask for a copy of your dental records. Your request must be in writing and must specify who you want to receive the records. The dental provider who has your records will provide you or the person you specified with a copy of your dental records.

Confidentiality: Dental records disclosed under A.R.S. §12-2293 remain confidential. If you participate in the appeals process, the relevant portions of your dental records may be disclosed only to people authorized to participate in the review process for the dental claim under review. These people may not disclose your dental information to any other people.

Documentation for an Appeal

If you decide to file an appeal, you must give us any material justification or documentation for the appeal at the time the appeal is filed. If you gather new information during the course of your appeal, you should give it to us as soon as you get it. You must also give us the address and telephone number where you can be contacted. If the appeal is already at Level 2, you should also send the information to the Department.

The Role of the Director of Insurance

Arizona law (A.R.S.§20-2533(F)) requires "any member who files a complaint with the Department relating to an adverse decision to pursue the review process prescribed" by law. This means, that for appealable decision, you must pursue the dental appeals process before the Insurance Director can investigate a complaint you may have against our company based on the decision at issue in the appeal.

The appeal process requires the Director to:

1. Oversee the appeals process.
2. Maintain copies of each utilization review plan submitted by insurers.
3. Receive, process, and act on requests from an insurer for External, Independent Review.
4. Enforce the decision of insurers.
5. Review decision of insurers.
6. Report to the Legislature
7. Send, when necessary, a record of the proceedings of an appeal to Superior Court or to the OAH.
8. Issue a final administrative decision on coverage issues, including the notice of the right to request a hearing at OAH.

Receipt of Documents

Any written notice, acknowledgment, request, decision, or other written document required to be mailed is deemed received by the person to whom the document is properly addressed on the 5th business day after being mailed. "Properly addressed" means your last known address.

Sun Life Assurance Company of Canada
PO Box 2940
Clinton Iowa 52733-2940
T 800.442.7742

DENTAL CARE APPEAL REQUEST

You may use this form to tell your insurer you want to appeal a denial decision.

Insured member's name _____ Member policy no. _____

Name of representative pursuing appeal, if different from above _____

Mailing Address _____ Phone no. _____

City _____ State _____ Zip code _____

Type of Denial: Denied Claim _____ Denied Service Not Yet Received _____

Name of Insurer that denied the claim _____

If you are appealing your insurer's decision to deny a service you have not yet received, will a 30 to 60 day delay in receiving the service likely cause a significant negative change in your health? If your answer is "Yes," you may be entitled to an expedited appeal. Your treating provider must sign and send a certification and documentation supporting the need for an expedited appeal.

What decision are you appealing *(Explain what you want your insurer to pay for.)* _____

Explain why you believe the claim or service should be covered *(Attach additional sheets of paper, if needed.)*

If you have questions about the appeals process or need help to prepare your appeal, you may call the Arizona Department of Insurance and Financial Institutions Consumer Assistance number 602.364.2499 or 800.325.2548, or call us at our toll-free number 800.442.7742.

Make sure to attach everything that shows why you believe your insurer should cover your claim, including:
☐ Dental Records ☐ Supporting Documentation (letter from your dentist, brochures, notes, receipts, etc.)

SIGNATURE OF INSURED OR AUTHORIZED REPRESENTATIVE DATE