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.

Policy Number:	966953-001
Policy Effective Date:	July 1, 2024
Policyholder:	Pathways Home Health and Hospice
Employer:	Pathways Home Health and Hospice
Issue State:	California
Amendment Effective Date:	July 1, 2025

FOR PERSONS AGE 65 AND OLDER: NOTICE OF RIGHT TO RETURN CERTIFICATE

Please read your certificate carefully. If you are age 65 or older and you are not satisfied, you may return this Certificate to your Employer within 30 days after you receive it. The amount of premium you have paid will be refunded, provided no claim has been incurred during this period. Your certificate will then be void, as though you had never applied for the insurance.

IMPORTANT: If you opt to receive dental services that are not covered services under this Policy, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call us at 1-888-222-3660 or call your insurance broker. To fully understand your coverage, you may wish to carefully review this Certificate.

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

NOTICE TO CERTIFICATE HOLDER

THIS NOTICE IS TO ADVISE YOU THAT SHOULD YOU HAVE ANY QUESTIONS OR COMPLAINTS REGARDING YOUR SUN LIFE GROUP INSURANCE PLAN OR YOUR ABILITY TO ACCESS NEEDED DENTAL CARE IN A TIMELY MANNER, YOU MAY CONTACT THE FOLLOWING:

SUN LIFE ASSURANCE COMPANY OF CANADA
ATTN: CUSTOMER RELATIONS
PO BOX 219932
KANSAS CITY, MO 64121
(800) 247-6875

ALSO AVAILABLE TO YOU IS

THE CONSUMER SERVICES DIVISION OF THE CALIFORNIA INSURANCE DEPARTMENT
300 SOUTH SPRING STREET, SOUTH TOWER, 11TH FLOOR, LOS ANGELES, CALIFORNIA 90013

(800) 927-4357

THE INSURANCE DEPARTMENT SHOULD BE CONTACTED ONLY AFTER DISCUSSIONS WITH THE INSURER HAVE FAILED TO PRODUCE A SATISFACTORY RESOLUTION TO THE PROBLEM

SPECIAL LANGUAGE ASSISTANCE NOTICE

In accordance with California Code of Regulation 2538.3, if you are a resident of California and prefer to communicate in a language other than English, we will provide an interpreter at no cost to you. To access this service, please use the customer service number at 1-888-222-3660. If you would like this document in Spanish at no additional cost to you, please contact Sun Life Employee Benefits Group at 1-888-222-3660. For more help, call the California Department of Insurance at 1-800-927-4357.

De acuerdo con el Código de Reglamentos de California 2538.3, si usted es residente de California y prefiere comunicarse en un idioma distinto al inglés, le proporcionaremos un intérprete sin costo para usted. Para tener acceso a este servicio, por favor utilice el número de servicio al cliente: 1-888-222-3660. Podría tener derecho a que ciertos documentos se traduzcan al español sin costo adicional para usted, por favor llame al Grupo de Beneficios para los empleados de Sun Life al 1-888-222-3660. Para obtener más ayuda llame al Departamento de Seguros de California (California Department of Insurance) al 1-800-927-4357.

Notice

Timely Access to Care

You have the right to timely access to care and telephone assistance, including the right to appointments and care within the following timeframes:

- Emergency care is available 24 hours a day, 7 days per week.
- Urgent care is available within 72 hours depending on individual dental needs and as required by professionally recognized standards of dental practice.
- Participating Providers must have an answering machine or answering service during non-business hours which provide instructions concerning how to obtain emergency or urgent care, including how to contact another provider who has agreed to be on-call to screen by phone or deliver emergency or urgent care.
- Non-urgent appointments are available within 36 business days of the request for an appointment.
- Preventive dental care appointments are available within 40 business days of the request for an appointment.
- We will ensure that, during normal business hours, a Customer Service Representative will answer the phone within 10 minutes.
- If it is necessary for you or the Participating Provider to reschedule an appointment, the appointment must be promptly rescheduled in a manner that is appropriate for your health care needs: within 24 hours for emergency care, within 72 hours for urgent care, within 36 business days for initial/routine care, and within 40 business days for preventative care.
- If you need an interpreter, interpretation services are available upon request. A request for interpretation services at the time of your appointment will not delay the scheduling of your appointment. We and provider will coordinate the interpretation services with the scheduled appointment.
- Participating Provider facilities should meet Americans with Disabilities Act (ADA) access guidelines including wheel-chair accessibility.

If medically appropriate care from a qualified provider is not accessible, care may be obtained from an accessible provider outside the network and cost-sharing will be equal to the cost-sharing you would have paid for similar service from an in-network provider. For Dependents who reside and work outside the service area, only coverage for Emergency dental services is available, and it is paid at the non-network rate.

If you have questions about appointment wait times or if you would like to request an interpreter, please contact our Client Service Department at 800-442-7742.

Communications Notice

Free services are available to help you communicate with us. Upon request, Sun Life will provide appropriate aids and services leading to effective communication for qualified persons with disabilities. In addition we can provide other services, such as, letters in other languages, or in other formats like large print. You can also ask for an interpreter at no charge. To ask for help, please call the toll-free number listed on your ID card.

Nondiscrimination Notice

Sun Life Assurance Company of Canada does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to us at complaints.mailbox@sunlife.com or PO Box 219932, Kansas City, MO 64121. You can also call 800-432-1102, extension 3557937.

Complaint Notice

You can file a complaint with the California Department of Insurance. Contact the Department of Insurance at 800-927-4357 or 213-897- 8921, by writing to the California Department of Insurance, Consumer Services Division, 300 Spring St., Los Angeles, CA 90013, or by visiting www.insurance.ca.gov.

In addition, you can submit a complaint to U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Phone: Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Notice

Confidentiality of Medical Information

You have the right to request that communications that disclose your medical information or provider name and address related to your receipt of medical services is communicated directly to you in an alternative manner or at an alternative location.

To request Sun Life* communicate with you about this information in an alternative manner or at an alternative location, send your written request to:

Sun Life
SLF US Compliance Department
Attention: HIPAA Privacy Officer
96 Worcester Street, Wellesley Hills, MA 02481

Your request must also specify how and where you wish to be contacted. For example, you can ask that we only contact you at your work address or via your work email.

For further questions about the information described in the notice, you may write to the above address or call 800-247-6875.

OUR HIPAA NOTICE OF PRIVACY PRACTICES CONTAINS ADDITIONAL INFORMATION DESCRIBING OUR PRIVACY PRACTICES, A PAPER COPY OF WHICH WILL BE FURNISHED UPON REQUEST.

*In this notice, ”Sun Life,” “we,” “us,” and “our” refer to Sun Life Assurance Company of Canada

Language Services

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-800-442-7742. For more help call the CA Dept. of Insurance at 1-800-927-4357.English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-800-442-7742. Para obtener más ayuda llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

免費語言服務。 您可獲得口譯員服務，用中文把文件唸給您聽。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 1-800-442-7742 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 與加州保險部聯絡。Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và được người khác đọc giúp tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-800-442-7742. Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese.

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 ID 카드에 나와있는 안내 전화 1-800-442-7742 번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아주 보험국에 안내 전화 1-800-927-4357 번으로 연락해 주십시오. Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipapabasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-800-442-7742. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Tagalog

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم و قراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-800-332-0366 للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357. Arabic

Անվճար լեզվական ծառայություններ: Դուք կարող եք ստանալ թարգմանիչ: Փաստաթղթերը կարող են ընթերցել ձեզ համար և դրանցից որոշներն ուղարկել ձեզ հայերեն լեզվով: Օգնության համար զանգահարեք ձեր ինքնության (ID) քարտի վրա նշված համարով կամ 1-800-442-7742 հեռախոսահամարով: Լրացուցիչ օգնության համար զանգահարեք Կալիֆորնիայի ապահովագրության բաժանմունք 1-800-927-4357 հեռախոսահամարով: Armenian

Tsis Xam Nqi Rau Cov Kev Pab Cuam Txhais Lus. Koj thov tau ib tus kws txhais lus. Koj tuaj yeem txais cov ntaub ntawv kom muab nyeem rau koj mloog los sis xa rau koj ua koj hom lus. Rau kev pab, hu rau peb tus nab npawb xov tooj tau teev tseg nyob rau ntawm koj daim npav ID los sis 1-800-442-7742. Rau kev paub ntxiv hu rau xeev California Chav Hauj Lwm ntsig txog Kev Tuav Pov Hwm (CA Dept. of Insurance) ntawm 1-800-927-4357. Hmong

無料の言語サービス日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または 1-800-442-7742 までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

សេវាកម្មភាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និង អានឯកសារជូនអ្នកជាភាសាខ្មែរ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខនៃលេខមានបង្ហាញនៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក ឬលេខ 1-800-442-7742។ សម្រាប់ជំនួយបន្ថែម សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ាតាមលេខ 1-800-927-4357។ ភាសាខ្មែរ Khmer

خدمات مجانی مربوط به زبان: میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگویید مدارک به زبان فارسی برایتان خوانده شود. برای دریافت کمک با ما از طریق شماره تلفنی که روی کارت شناسایی شما قید شده است و یا این شماره 1-800-442-7742 تماس بگیرید. برای دریافت کمک بیشتر، به اداره CA Dept. of Insurance) به شماره 1-800-927-4357 تلفن کنید. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾਂ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-800-442-7742 'ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-800-442-7742. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

मुफ़्त भाषा सेवाएं. आप दस्तावेज़ों को हिन्दी में पढ़वाने के लिए एक इंटरप्रेटर नियुक्त कर सकते हैं. मदद पाने के लिए ,अपने आईडी कार्ड पर दिए गए नंबर या 1-800-442-7742 पर कॉल करें. अगर आपको हमसे कोई और मदद चाहिए ,तो कैलिफोर्निया डिपार्टमेंट ऑफ़ इंशोरेंस को1-800-927-4357 पर कॉल करें. Hindi

บริการภาษาโดยไม่เสียค่าใช้จ่าย คุณสามารถขอรับบริการล่ามเพื่ออ่านเอกสารให้คุณฟังในภาษาไทยได้ โทรขอความช่วยเหลือจากเราได้ตามเบอร์ที่อยู่บนบัตรประจำตัวของคุณหรือหมายเลข 1-800-442-7742 หรือโทรหากรมประกันภัยแห่งรัฐแคลิฟอร์เนีย (Department of Insurance) ที่เบอร์ 1-800-927-4357 เพื่อขอความช่วยเหลือเพิ่มเติม Thai

GDFM-1332-082021

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.

What can you do if network providers are not available in your service area?
If medically appropriate care from a qualified provider is not accessible, care may be obtained from an accessible provider outside the network and cost-sharing will be equal to the cost-sharing you would have paid for similar service from an in-network provider.

Coverage for emergency dental services is available, and it is paid at the non-network rate.

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.

DISCLOSURE OF INFORMATION

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 your plan. 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; 90% coinsurance for Network Expenses rendered by a Participating Provider; and 90% coinsurance for Non-Network Expenses rendered by a Non-Participating Provider.

DISCLOSURE OF INFORMATION

	Network Expenses (Participating Provider)	**Non-Network Expenses (Non-Participating Provider)**
$130 Covered Type I Dental Service		
Cash Deductible	None	None
Sun Life Pays Network Expense: 90% of Allowable Charge for Participating Providers ($105)	$105 (Allowable Charge) X 90% $94.50	
Non-Network Expense: 90% of Allowable Charge for Non-Participating Providers ($125)		$125 (Allowable Charge) x90% $112.50
Plan Pays	$94.50	$112.50
You Pay	**$10.50**	**$17.50**

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?

If you need an interpreter, interpretation services are available upon request. A request for interpretation services at the time of your appointment will not delay the scheduling of your appointment.

If you have questions about appointment wait times or if you would like to request an interpreter, please contact us at:

Sun Life Assurance Company of Canada
Director, Dental Benefits
PO Box 419057
Kansas City, MO 64141
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 Part-Time United States Employees working in the United States scheduled to work at least 20 hours per week, excluding Employees enrolled in the Alternate Plan

Eligibility Waiting Period: Until the first of the month coincident with or next following 30 days of employment

Deductible:

Per Person Deductible: $50 per Calendar Year

Maximum Family Deductible: 3 persons individually per Calendar Year

Only one deductible applies per Calendar 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 Calendar Year.

The Per Person Maximum Benefit for Type IV expenses is:
$1,000 per Lifetime

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%

Oral Evaluations
Bite Wing X-Rays
Dental Prophylaxis
Genetic Test
Fluoride Treatment
Space Maintainers
Sealants
Intraoral Complete Series
Extraoral X-Rays
Intraoral Occlusal X-rays
Intraoral Periapical X-rays

Type II Covered Dental Expenses
Payable at: 80%

Palliative Treatment
Scaling and Root Planing
Full Mouth Debridement
Periodontal Maintenance
Localized Delivery of Time Release Anti-microbial Agents into Diseased Crevicular Tissue
Root Canal Therapy
Apicoectomy/Periradicular Surgery

EMPLOYEE, SPOUSE AND DEPENDENT CHILDREN DENTAL INSURANCE

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
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
Amalgam Restoration
Stainless Steel Crowns
Repair/Recement Full Dentures, Partial Dentures, Crowns, Inlays
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: 50%

Crowns
Inlays and Onlays
Fixed Bridge
Removable Full or Partial Dentures
Crown Buildup
Post and Core
Tissue Conditioning
Veneers
Clasps and Rests
Relining Dentures, Rebasing Dentures
Denture Adjustments
Occlusal Guard
Implants

Type IV Covered Dental Expenses
Payable at: 50%

Diagnostic X-rays*
Orthodontic Treatment
Orthodontic Appliance
Surgical Extraction of Impacted Teeth
Study Models
Harmful Habit Appliance

*Diagnostic X-rays are limited to x-rays to determine the current position of the teeth for orthodontic purposes.

Contributions: The cost of your insurance is shared by both you and your Employer.

2. DEFINITIONS

Actively at Work means that you perform 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 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.

Authorized Representative means a person granted authority by you to act on your behalf regarding a claim for benefits or an appeal of a claim denial. An assignment of benefits is not a grant of authority to act on your behalf in pursuing and appealing a benefit determination.

Calendar Year means the period beginning on January 1st and ending on December 31st of the same year.

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 for the dental care of an Insured; and
- determined to have a reasonably favorable prognosis.

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.

2. DEFINITIONS

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 or a child of your civil union partner or domestic partner, as defined by the Policyholder;
- a foster child placed with you by a licensed agency;
- your adopted child, including any child placed with you for adoption.

If a 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; 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 or part-time Employee will count towards completion of the Eligibility Waiting Period.

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.

2. DEFINITIONS

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 and (b) the following relatives of you or your spouse: (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.

Immediate Family includes:
- you;
- your Spouse; and
- the parents, grandparents, brothers, sisters or children of either you or your Spouse, whether related by blood or marriage.

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

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 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.

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.

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 and a same-sex or opposite-sex registered domestic partnership as defined in California Family Code Section 297; or
- is a domestic partner as defined by the Policyholder.

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:

- July 1, 2024;
- 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.

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.

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 12 months 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.

3. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF EMPLOYEE INSURANCE

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:

- July 1, 2024;
- 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 open Enrollment Period or as a result of a Family Status Change, provided you are in an Eligible Class and have a Spouse.

What if my Spouse is an Employee of the Employer?
If your Spouse is an Employee of the Employer, he or she may not be covered as both an Employee and a Dependent.

What if my Spouse is not living in the United States?
If your Spouse is permanently residing outside the United States, he or she may not be covered. This exclusion does not apply to your Spouse who resides with you while you are on a temporary work assignment outside the United States.

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 open Enrollment Period.

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 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:

- July 1, 2024;
- 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 open 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.

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 on that date 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 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.

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, Type III or Type IV. 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 accomplish a professionally satisfactory result. If you and the Dentist agree to a more costly method of Treatment, the excess amount will not be paid by us.

Pre-Determination of Benefits is not 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 Calendar 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; and
- limited to the Calendar Year Maximum Benefit.

What benefits are payable for Type IV Covered Dental Expenses?
The benefit payable will be:

- equal to the percentage shown in the Benefit Highlights for Type IV Covered Dental Expenses; and
- limited to the Lifetime Maximum Benefit.

The initial benefit payable will:

- be determined by the amount of Type IV Covered Dental Expenses for the diagnosis and/or placement of the bands or appliance; and
- not exceed 25% of the total benefit.

Any remaining benefit for Type IV Covered Dental Expenses Incurred for remaining Treatment will be payable on a quarterly payment schedule as long as Treatment continues and insurance is in force. In no event will the total benefit be payable in one sum at the start of Treatment.

What is the Deductible?
The Per Person Deductible is the amount of Covered Dental Expenses that an Insured must Incur in a Calendar Year before any benefits are payable. The Per Person Deductible per Calendar 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.

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

The Maximum Family Deductible shown in the Benefit Highlights is the number of Insureds in your family who must each Incur Covered Dental Expenses in excess of the Per Person Deductible. Once the Maximum Family Deductible is met, Covered Dental Expenses are payable even if the Per Person Deductible has not been met.

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

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

What is the Lifetime Maximum Benefit?
The Per Person Lifetime Maximum Benefit payable for any Insured who Incurs Type IV expenses is shown in the Benefit Highlights.

Does your Treatment have to have a favorable prognosis?
Benefits will be considered only for Treatment that 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.

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.

6. COVERED DENTAL BENEFITS

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.

Covered Dental Expenses include services provided using teledentistry technologies and methods (synchronous or asynchronous) delivered to an Insured to the same extent that the services would be covered if they were provided through in-person encounters.

TYPE I DENTAL SERVICES
Oral Evaluations

Oral Evaluations are limited to 2 of these services in any 12 consecutive month period. Oral evaluations performed during a customary preventive exam will count towards the covered expense limit for oral evaluations.

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

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 36 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.

Dental Prophylaxis
Dental Prophylaxis is limited to 2 times in any 12 consecutive month period. The number of Dental Prophylaxis and Periodontal Maintenance is combined and is limited to 2 times 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 19.

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

Diagnostic Services
Accession and Examination of Tissue

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
The number of Periodontal Maintenance and Dental Prophylaxis is combined and is limited to 2 times in any 12 consecutive month period.

Full Mouth Debridement
Full mouth debridement is limited to 1 time per lifetime.

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

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.

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.

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.

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.

TYPE III DENTAL SERVICES

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 5 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 5 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 5 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 5 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 5 year period.

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 5 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 5 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 5 year period and only if the Bridge cannot be made serviceable.

Implant Services
Implants
Implants are limited to 1 in any 5 year period and only if the Implant cannot be made serviceable. Implant abutments are limited to 1 per Implant.

Other Type III Services

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

TYPE IV ORTHODONTIC DENTAL SERVICES

The Benefit Waiting Period will not be applied if the Insured was enrolled in the Prior Plan.

Diagnostic X-rays
Diagnostic X-rays are limited to x-rays for orthodontic purposes.

Surgical Extraction of Impacted Teeth
Surgical Extraction of Impacted Teeth is limited to Treatment for orthodontic purposes.

Orthodontic Treatment

Study Models

Orthodontic Appliance For Tooth Guidance

Harmful Habit Appliance

Are any benefits payable for Type IV Orthodontic Dental Services started prior to an Insured's effective date of insurance under the Policy?
Benefits may be payable for Orthodontic Treatment under the Policy if the Insured was covered under your prior group dental policy.

If initial placement of an orthodontic appliance was made prior to an Insured's effective date of insurance, the benefits payable will be reduced by the portion attributed to the initial placement.

For periodic follow up visits for orthodontic dental services started prior to an Insured's effective date of insurance, the total amount of the benefits payable for periodic visits will be reduced accordingly.

The Lifetime Maximum Benefit payable under the Policy for any Insured who Incurs Type IV Covered Dental Expenses prior to your effective date of insurance under the Policy will be reduced by the amount of any benefits paid and/or payable under your prior group dental policy provided:

- the Insured had not reached the maximum benefit payable under your prior group dental policy; and
- the maximum benefit under your prior group dental policy is equal to or greater than the Lifetime Maximum Benefit under the Policy.

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;
  - is a member of your Immediate Family;
  - 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.
- 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 by you or another person;
  - dental care resulting from active Participation in a Riot; Rebellion, or Insurrection;
  - dental care resulting from the commission or attempted commission of a felony.
- dental care arising out of or in the course of employment for pay or profit or which is actually paid by Workers' Compensation or a similar law, or for which the Insured is actually paid 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.
- procedures that are cosmetic in nature.

7. EXCLUSIONS

- replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.
- 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 be satisfactorily restored with an amalgam or composite filling.
- charges for replacement of bridges, partial or full dentures, inlays, onlays, crowns, implant crowns and other laboratory prepared restorations if they can 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 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) commencing prior to two years from the Insured’s effective date of insurance.

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 within 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.

Notice given by or on behalf of the Insured or the Beneficiary to us or to any authorized agent with information sufficient to identify the Insured, shall be deemed notice to us. If notice cannot be given within the applicable time period, we must be notified as soon as it is reasonably possible.

Upon receipt of a Written notice of claim, we will furnish to the claimant such forms as are usually furnished by it for filing proofs of claim. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of the Policy as to proof of claim upon submitting within the time fixed in the Policy for filing proofs of claim, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

PROOF OF CLAIM

When does Written proof of claim have to be submitted?
Written proof of claim must be furnished to us within 90 days after the date the expense is Incurred.

Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

What is considered proof of claim?
Proof of claim must consist of at least the following information:

- 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.
- completion of a brief questionnaire which will specify:
  - the degree of overjet, overbite, crowding, open bite;
  - if teeth are impacted in crossbite, or congenitally missing;
  - the length of Treatment; and
  - the total charge for the Treatment.
- any other information we may reasonably require to make a claim determination.

8. CLAIM PROVISIONS

We may reasonably require as part of the proof, authorizations to obtain dental and non-dental information.

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 payable under the Policy for any claim will be paid immediately upon receipt of due written proof of claim.

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?
If all or part of your claim is denied, you may request in Writing a review of the denial within 180 days after receiving notice of denial.

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, your Dentist or your Authorized Representative 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.

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.

8. CLAIM PROVISIONS

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 Calendar 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.

8. CLAIM PROVISIONS

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.

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 1 month;
- Leave of Absence – up to 1 month;
- 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

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.

Cal-COBRA State Law

Each Insured who loses coverage for one of the following Qualifying Events may elect continuation coverage for the same benefits he or she was provided under The Policy on the day before the Qualifying Event, subject to the terms and conditions of the Policy for active participants. Any deductibles, benefit amounts, co-payments, allowances or limits on benefits payable under the continuation will be reduced by any corresponding amounts or limitations previously paid or satisfied under the Policy on the date before Insured became ineligible.

9. INSURANCE CONTINUATION

Qualifying Events

1. Your termination of employment (other than by reason of gross misconduct), or reduction in hours;
2. Your death;
3. Your divorce or legal separation from Your Spouse;
4. Your becoming entitled to benefits under Medicare; or
5. Your Dependent Child ceasing to qualify as a Dependent under The Policy.

Each Insured shall:

1. send a written request for continuation to the Employer within 60 days following the later of:
   - the date of the Qualifying Event;
   - the date the Insured is given notice of the right to continue coverage; or
   - the date coverage under the group Policy terminates; and
2. pay the required premium within 45 days of the date of the request to continue.

Continuation shall end on the earliest of the following dates:

1. 18 months after the Qualifying Event if due to termination of employment or reduction in hours;
2. If the Social Security Administration determines an Insured to be disabled on the date of the Qualifying Event or within 60 days afterward, 29 months, as long as he or she:
   - notifies the Employer of the Social Security determination prior to the end of the original 18 month period; and
   - provides the Employer with a copy of the Social Security determination of disability within 60 days of the Social Security Administration's decision.

   If an Insured is no longer disabled under Title II or Title XVI of the Social Security Act, benefits shall terminate on the later of 18 months or the month that begins more than 31 days after the date of the final determination that the Insured is no longer disabled.
3. 36 months after the Qualifying Event for all other Qualifying Events; your class;
4. the end of the period for which timely premium payments were made,
5. the date the Insured is entitled to benefits under Medicare; or
6. the date the Insured becomes covered under any Group Health Plan. However, the Insured may keep these continuance provisions provided:
   - he or she has a pre-existing condition; and
   - the new Group Health Plan contains a pre-existing limitation for that condition.

If while on an 18 month continuation, your Spouse or Dependent Child ceases to be eligible for continuation benefits due to any of the Qualifying Events other than termination of employment or reduction in hours, your Spouse of Dependent Child will be entitled to continuation for up to 36 months measured from the beginning of the 18 month continuation under which such person was covered.

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 July 1, 2024 if:

- you were insured under the Prior Plan on the day before July 1, 2024;
- 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 July 1, 2024 if:

- your Spouse or Dependent Child was insured under your Employer's Prior Plan on the day before July 1, 2024;
- 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 this 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.

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 Calendar 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 Calendar 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.

The Lifetime Maximum Benefit payable under the Policy for any Insured who Incurs Type IV Covered Dental Expenses under the Prior Plan will be reduced by the amount of any benefits paid and/or payable under the Prior Plan provided:

- the Insured had not reached the maximum benefit payable under the Prior Plan; and

- the maximum benefit under the Prior Plan is equal to or greater than the Lifetime Maximum Benefit under the Policy.

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

LEGAL PROCEEDINGS

What are the time limits for legal proceedings?
No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after Written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of 3 years after the time Written proof of loss is required to be furnished.

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 the Employer or Employee has performed an act or practice constituting fraud or made an intentional misrepresentation of material fact as prohibited by the terms of the Policy:

- 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.

After two years from the Policy Effective Date, no act or practice constituting fraud or intentional misrepresentation of material fact shall be used to void 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.

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.

11. GENERAL PROVISIONS

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

Group Dental Certificate

Non-Participating

Pathways Home Health and Hospice 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: Pathways Home Health and Hospice
585 N Mary Ave
Sunnyvale, CA 94085

Plan Administrator: Pathways Home Health and Hospice
585 N Mary Ave
Sunnyvale, CA 94085

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

Agent for Service of Legal Process: Pathways Home Health and Hospice
585 N Mary Ave
Sunnyvale, CA 94085

Employer Identification Number (EIN): 94-2823240

Plan Number: 501

End of Plan Year: June 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.