SUN LIFE ASSURANCE COMPANY OF CANADA

Executive Office:
One Sun Life Executive Park
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.

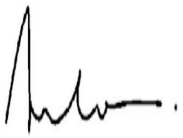
Policy Number:	911523-001
Policy Effective Date:	September 1, 2018
Policyholder:	Temple Independent School District
Employer:	Temple Independent School District
Issue State:	Texas

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

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.

Signed at Wellesley Hills, Massachusetts.



Dean A. Connor
President and Chief Executive Officer

Brigitte K. Catellier
Vice-President, Associate General Counsel and Corporate Secretary

Group Dental Certificate

Non-Participating

Sun Life Financial®

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Sun Life Assurance Company of Canada's toll free telephone number for information or to make a complaint at:

1-888-222-3660

You may also write to Sun Life at:

Sun Life Assurance Company of Canada
Group Customer Service Center SC 1219
1 Sun Life Executive Park
Wellesley Hills, MA 02481

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714 9104
FAX: (512) 490-1007
Web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim, you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para presentar una queja:

Usted puede llamar al numero de telefono gratuito de Sun Life Assurance Company of Canada's para obtener informacion o para presentar una queja al:

1-888-222-3660

Usted tambien puede escribir a Sun Life:

Sun Life Assurance Company of Canada
Group Customer Service Center SC 1219
1 Sun Life Executive Park
Wellesley Hills, MA 02481

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener informacion sobre companias, coberturas, derechos o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104
Austin, TX 78714 9104
FAX: (512) 490-1007
Sitio web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES: Si tiene una disputa relacionada con su prima de seguro o con una reclamacion, usted debe comunicarse con la compania primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU POLIZA: Este aviso es solamenta para propositos informativos y no se convierte en parte o condicion del documento adjunto

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 Plan?
The Sun Life Dental 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 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 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 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 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 a greater benefit 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.sunlifedentalbenefits.com.

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

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

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

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

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

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

if the Maximum Benefit was reached since the Pre-Determination was processed. **Please be sure to read the Certificate carefully to ensure coverage is provided under your Policy.**

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

What are your benefits?
The "Benefit Highlights" and "Covered Dental Benefits" sections of the Certificate contain information regarding benefits including benefit maximums and limitations. The "Benefit Highlights" section outlines the benefit levels for 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.

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

DISCLOSURE OF INFORMATION

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

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

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

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

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

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1. BENEFIT HIGHLIGHTS

EMPLOYEE, SPOUSE AND DEPENDENT CHILDREN DENTAL INSURANCE

Eligible Class: All Full-Time United States Employees working in the United States scheduled to work at least 20 hours per week, excluding Employees enrolled in the Alternate Plan

Eligibility Waiting Period: Until the first of the month following date of employment

Benefit Plan: Basic Benefit Plan

If you enrolled for this option, Dental insurance for all Insureds you elect to enroll will be based on the following:

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 Dental Expenses are Incurred. The deductible is waived for Type I Dental Expenses.

Maximum Benefit:

The Per Person Maximum Benefit for Type I and II Dental Expenses combined is:
$750 per Calendar Year.

Covered Dental Benefits

Unless otherwise specified, the following benefits will be payable. 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
Simple Extraction
General Anesthesia/IV Sedation
Amalgam Restoration
Accession and examination of tissue
Pin Retention
Therapeutic Drug Injections
Consultation
Composite and Silicate Restorations

1. BENEFIT HIGHLIGHTS

EMPLOYEE, SPOUSE AND DEPENDENT CHILDREN DENTAL INSURANCE

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

2. DEFINITIONS

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

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

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

Allowable Charge means:

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

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

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

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, as determined by us, for the dental care of an Insured; and
- determined by us to have a 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 he or she practices; and
- is acting under the supervision of a Dentist.

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

Dental Prophylaxis means preventive Treatment which includes scaling and polishing, the complete removal of explorer-detectable calculus, soft deposits, plaque, stains and the smoothing of tooth surfaces coronal to the gingival attachment. A multiple appointment cleaning shall be considered as a single prophylaxis.

Dentist means someone who meets both of the following requirements:
- is currently licensed to practice dentistry by the state in which he or she practices; and
- is acting within the scope of his or her license.

Denturist means someone who meets both of the following requirements:
- is currently licensed to make dentures by the state in which he or she practices; and
- is acting within the scope of his or her 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 insured child under age 26.

Dependent Child includes:
- your step-child;
- a foster child placed with you by a licensed agency;
- your adopted child, including any child placed with you for adoption or who is the subject of a suit for adoption;
- a child of your Spouse.

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

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

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

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

Divorce means the dissolution of any relationship identified in the Marriage definition and the court-issued document appropriate for the termination of such a relationship.

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.

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 or who is the subject of a suit for adoption;
- the requirement of a court order to include coverage for your child or stepchild;
- the death of your Spouse or child;
- 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, civil union partner or domestic partner; 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.

Late Entrant means:

- an Employee who does not enroll during the times specified in the “Eligibility, Effective Dates and Termination of Employee Insurance” section;
- a Spouse who you do not enroll during the times specified in the “When must you enroll for Spouse Dental insurance?” section;
- a Dependent Child who you do not enroll during the times specified in the “When must you enroll for Dependent Dental insurance?” section; or
- any Insured who requests reinstatement of insurance which was terminated while he or she remained eligible for insurance under the Policy.

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

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

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

Marriage means any of the following relationships as recognized under local, state, federal or provincial law: a same-sex or opposite-sex marriage; a civil union partnership under which the partners have the same legal rights and responsibilities as a married couple; and a same-sex or opposite-sex registered domestic partnership under which the partners have the same legal rights and responsibilities as a married couple.

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 or Contracting Provider.

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

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

Participation in a Riot, Rebellion or Insurrection, the words "Participation" and "Riot" in this phrase mean:
Participation includes promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but will not include actions taken in defense of public or private property, or actions taken in your own defense, if such actions of defense are not taken against persons seeking to maintain or restore law and order including but not limited to police officers and firefighters.

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

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

2. DEFINITIONS

Physician means a person who is operating within the scope of his or her 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 law to have the same authority as a legally qualified medical doctor.

The Physician cannot be you.

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.

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; 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. 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:

- September 1, 2018;
- the first day of the month following your date of employment; or
- the date you first are Actively at Work in an Eligible Class.

You are also eligible for 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?
You must enroll within 31 days of the date you are initially eligible for Employee Dental Insurance.

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

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

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

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

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

if you are Actively at Work on that date.

What are the Employee Benefit Waiting Periods?
You will be insured for Type I Dental Expenses on your Effective Date of Insurance. There is a Benefit Waiting Period for Type III Dental Expenses as shown below. The Benefit Waiting Period begins on your Effective Date.

The Benefit Waiting Period for Type III Dental Expenses is 12 months.

If you are a Late Entrant you will be insured for Type I Dental Expenses on your Effective Date of Insurance. There is Benefit Waiting Period for Dental Expenses as shown below. The Benefit Waiting Periods begin on your Effective Date.

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

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

- the date the Policy terminates;
- the date you are no longer in an Eligible Class;
- the date your class is no longer included for insurance;
- the last day for which any required premium has been paid for your Employee Dental Insurance;
- the date you request in Writing to end your Employee Dental Insurance;
- the last day of the month in which you are Actively at Work, subject to the Insurance Continuation provision;
- the date you enter active duty in any armed service during time of war, declared or undeclared;
- the last day of the month in which you retire; or
- the date you die.

If your coverage has ended, can it be reinstated?
If your insurance ends for any reason other than you have voluntarily terminated it, then you may apply to reinstate your insurance within 12 months from the date it ended. To reinstate, 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 of the date:

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

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

A new Eligibility Waiting Period will not apply.

Your reinstated insurance will be:

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

4. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF SPOUSE INSURANCE

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

- September 1, 2018;
- the date you are insured for Employee Dental Insurance; or
- the date you acquire a Spouse.

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

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

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

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

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

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

What are the Spouse Benefit Waiting Periods?
Your Spouse will be insured for Type I Dental Expenses on your Spouse's Effective Date of Insurance. There is a Benefit Waiting Period for Type III Dental Expenses as shown below. The Benefit Waiting Period begins on your Spouse's Effective Date.

The Benefit Waiting Period for Type III Dental Expenses is 12 months.

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

What if my 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 will end on the earliest of the following to occur:

- the date the Policy terminates;
- the date you are no longer in an Eligible Class;
- the date your class is no longer included for insurance;
- the last day for which any required premium has been paid for your insurance or your Spouse Insurance;
- the date you are no longer insured under the Policy;
- the date you request in Writing to end your Spouse Dental Insurance;
- the last day of the month in which you are Actively at Work, subject to any Insurance Continuation provisions provided;
- the date your Spouse enters active duty in any armed service during time of war, declared or undeclared;
- the date your Spouse no longer meets the definition of Spouse as described in this Certificate;
- the last day of the month in which you retire;

- the date you die; or
- the date your Spouse dies.

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:

- September 1, 2018;
- the date you are insured for Employee Dental Insurance; or
- the date you acquire your Dependent Children.

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

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

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

or your Dependent Child will be a Late Entrant.

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; or
- you agree to make any required contribution toward the cost of insurance;

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

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

What are the Dependent Children Benefit Waiting Periods?
Your Dependent Child will be insured for Type I Dental Expenses on your Dependent Child's Effective Date of Insurance. There is a Benefit Waiting Period for Type III Dental Expenses as shown below. The Benefit Waiting Period begins on your Dependent Child's Effective Date.

The Benefit Waiting Period for Type III Dental Expenses is 12 months.

If you are a Late Entrant or your Dependent Child is a Late Entrant your Dependent Child will be insured for Type I Dental Expenses on your Dependent Child's Effective Date of Insurance. There is Benefit Waiting Period for Dental Expenses as shown below. The Benefit Waiting Periods for Late Entrants begin on your Dependent Child's Effective Date.
The Benefit Waiting Periods shown above will not be applied if your Dependent Child was enrolled in the Prior Plan or Alternate Plan.

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

How does Dependent Children Dental Insurance apply to newborn children, newly placed foster children, newly adopted children or children who are the subject of a medical support order?
If you are insured under the Policy but do not have Dependent Children Dental Insurance when a newborn child, newly placed foster child, newly adopted child or child who is the subject of a medical support order becomes one of your Dependent Children, then such child will automatically be covered for 31 days from the date he or she becomes 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, newly adopted child or child who is the subject of a medical support order 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, newly adopted child or child who is the subject of a medical support order becomes one of your Dependent Children, then such child will automatically be covered.

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

- the date the Policy terminates;
- the date you are no longer in an Eligible Class;
- the date your class is no longer included for insurance;
- the last day for which any required premium has been paid for your insurance or your Dependent Children Dental Insurance;
- the date you are no longer insured under the Policy;
- the date you request in Writing to end your Dependent Children Dental Insurance;
- the last day of the month in which you are Actively at Work, subject to any Insurance Continuation provisions provided;
- the date your Dependent Child enters active duty in any armed service during time of war, declared or undeclared;
- the date your Dependent Child no longer meets the definition of Dependent Child as described in this Certificate, but only with respect to that person; or
- the last day of the month in which you retire; or
- the date you die; or
- the date your Dependent Child dies.

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 type of service – Type I or Type II. 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 this Policy; or
- any Treatment for which charges will exceed $500.

We recommend that the Course of Treatment be submitted to us for review before Treatment begins. We will notify you and the Dentist of the benefits payable based upon the Course of Treatment. In determining the amount of benefits payable, we will consider alternate dental Treatment that will, as determined by us, accomplish a professionally satisfactory result. If you and the Dentist agree to a more costly method of Treatment, than that determined by us, the excess amount will not be paid by us.

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

What is the alternate dental Treatment benefit?
If we determine that alternate procedures, services or Courses of Treatment can be performed to correct a dental condition, payment will be considered for the least costly procedure which we determine will produce a professionally satisfactory result. No alternate dental Treatment benefit is payable for any service that is not a Covered Dental Expense.

Under what conditions are benefits payable?
Our payment of benefits is subject to all the terms and conditions of the Policy. We will not pay benefits for any one item of expense under more than one provision of the Policy. All related dental expenses will be considered as part of the most comprehensive procedure and only the benefit for that procedure will be payable.

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

If an Insured uses the services of a Non-Participating Provider, that provider is entitled to collect from you the difference between the amount of benefits payable by us and the provider's billed charge.

What benefits are payable for Type I and Type II 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;
- subject to any Benefit Waiting Periods; and
- limited to the Calendar Year Maximum Benefit.

6. COVERED DENTAL BENEFITS

What is the Deductible?
The Per Person Deductible is the amount of Covered Dental Expenses that an Insured must Incur in a 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 and II 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 interruption in coverage for this insurance. This Maximum Benefit applies to all Covered Dental Expenses.

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

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

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 this Policy; and
- until the end of the calendar year quarter in which insurance ends, for Orthodontic Treatment Incurred while covered under the Policy if such services are included under the Policy.

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

What happens if you were covered under the Employer's Alternate Plan?
If an Insured was covered under the Employer's Alternate Plan:

- the Maximum Benefit and any other limits on amounts or time limitations on benefits payable under this 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 Alternate Plan.
- Covered Dental Expenses that are used to satisfy the Alternate Plan's deductible provisions will be applied toward the satisfaction of the deductible provisions of this Policy.

6. COVERED DENTAL BENEFITS

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.

TYPE I DENTAL SERVICES
Oral Evaluations

Oral Evaluations are limited to 2 of these services in any Calendar Year.

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 60 consecutive month period. Ten or more individual periapical x-rays and/or bitewing films or a panoramic film will be considered a complete series for benefit purposes.

Dental Prophylaxis
Dental Prophylaxis is limited to 2 of these services in any Calendar Year. The number of Dental Prophylaxis and Periodontal Maintenance is combined and is limited to 2 of these services in any Calendar Year.

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 16.

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 teeth that have not, or will not develop. Benefits include all adjustments within 6 consecutive months of installation.

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

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

Diagnostic Services
Accession and Examination of Tissue

Oral Surgery Services

Simple Extraction

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 2 tooth surfaces in any 24 consecutive month period. Restorations on posterior teeth will be payable as an amalgam restoration. 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.

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:
  - is an employee of the Policyholder; or
  - is a Policyholder.
- charges for Treatment that is not Dentally Necessary or not deemed to be within generally accepted standards of dental Treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the determination will be made by us.
- charges for completion of claim forms or failure to keep appointments.
- charges for any of the following:
  - dental care resulting from war or an act of war, or any involvement in any period of any type of armed conflict (this does not include acts of terrorism);
  - active participation in a war (declared or undeclared);
  - active military duty;
  - dental care resulting from any injury which is self-inflicted or not caused by an accident;
  - dental care resulting from active Participation in a Riot; Rebellion, or Insurrection;
  - dental care resulting from the commission or attempted commission of an assault, felony or other criminal act.
- dental care arising out of or in the course of employment for pay or profit or which is covered by Workers' Compensation or a similar law, or for which the Insured is entitled to payment under an automobile insurance policy. Benefits paid by us would be in excess to the third-party benefits and therefore, we would have the right of recovery for any benefits paid in excess.
- Covered Dental Expenses Incurred while insurance is not in force under the Policy.
- charges for incomplete Treatment (e.g. patient does not return to complete Treatment) and charges for temporary services (e.g. temporary restorations).
- charges for care, Treatment, services, or supplies to the extent that any benefit is provided by Medicare.
- charges which are not customarily made when there is no insurance, or charges for which there is no legal obligation to pay.
- charges for Treatment performed outside the United States except for a Maximum Benefit of $100 for emergency dental Treatment performed outside the United States.
- procedures which are elective.
- procedures that we determine are cosmetic in nature.

7. EXCLUSIONS

- replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.
- implants; implant abutments; implant supported crowns, bridges or dentures; or any other service for the care and Treatment of an implant.
- specialized procedures and techniques (e.g. precision or semi-precision attachments, copings, over dentures or customized prostheses or attachments).
- a fixed bridge that replaces the extracted portion of a hemisected tooth.
- duplicate dentures, prosthetic devices or any other duplicative device.
- charges for bridges, partial or full dentures, inlays, onlays, crowns, implant crowns and other laboratory prepared restorations if they can, as determined by us, be satisfactorily restored with an amalgam or composite filling.
- charges for replacement of bridges, partial or full dentures, inlays, onlays, crowns, implant crowns and other laboratory prepared restorations if they can, as determined by us, be satisfactorily repaired and restored to function.
- charges for pulp caps.
- charges for diagnostic casts.
- charges for Treatment of fractures and dislocations of the jaw.
- charges for Treatment of malignancies or neoplasms.
- charges for desensitizing medications.
- administration of nitrous oxide or other agent to control anxiety.
- charges for occlusal adjustments.
- charges for periodontal splinting of teeth by any method.
- charges for orthodontic Treatment.
- charges for retention of orthodontic relationships.
- charges for Treatment or appliances whose primary purpose is to:
    - change or maintain vertical dimension;
    - alteration or restoration of occlusion, except for occlusal adjustment in conjunction with periodontal surgery;
    - bite registration, or bite analysis;
    - treat attrition or abrasion.
- charges for diagnostic services and Treatment of jaw joint problems by any method. Examples of these jaw joint problems are temporomandibular joint disorders or other conditions of the joint linking the jaw bone and the complex muscles, nerves and other tissues related to the joint.
- charges for any Treatment of congenital mouth malformations or skeletal imbalances (e.g. Treatment related to cleft lip or cleft palate, disharmony of facial bone or required as the result of orthognathic surgery including Orthodontic Treatment).

8. CLAIM PROVISIONS

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

NOTICE OF CLAIM

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

CLAIM FORMS

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

PROOF OF CLAIM

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

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

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

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

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

PAYMENT OF BENEFITS
When will a decision on your claim be made?
We will send you a Written notice of our decision on your claim within a reasonable time after we receive the claim but not later than 15 business days after we receive all items, statements and forms required by us. We will advise you during that time if we need additional information. We may request an extension of up to 45 days from such date. Any request for extension will specifically explain:

- the standards on which entitlement to benefits is based;

- the unresolved issues that prevent a decision on the claim; and
- the additional information needed to resolve those issues.

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

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

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

- the specific reasons for the denial;
- the specific Policy provisions on which the denial is based;
- your right to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits;
- a description of any additional material or information needed to prove entitlement to benefits and an explanation of why such material or information is necessary;
- a description of the appeal procedures and time limits;
- 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 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;
- 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, possessory or managing 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; or
- 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.

However, we will pay the Texas Department of Human Services for claims submitted on behalf of your Dependent Children that are paid by them under financial and medical assistance service programs administered under the Human Resources Code, if the following conditions exist:
- you have possession or access of the child under a court order; or
- you are not entitled to access or possession of the child and are required by the court to pay child support.

We must receive written notice attached to the claim when it is submitted, which states that all benefits paid must be paid directly to the Texas Department of Human Services.

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 this Policy, so that the combined benefits will not be more than the Allowable Expenses of this Policy and any other Plan.

What is a Plan?
For purpose of Coordination of Benefits (COB), a Plan is any of the following that provides benefits or services for dental care or Treatment:

- group, blanket, or franchise accident and health insurance policies, excluding disability income protection coverage;
- individual and group health maintenance organization evidences of coverage;
- individual accident and health insurance policies;
- individual and group preferred provider benefit plans and exclusive provider benefit plans;
- group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care;
- dental care components of individual and group long-term care contracts;
- limited benefit coverage that is not issued to supplement individual or group in-force policies;
- uninsured arrangements of group or group-type coverage;
- the medical benefits coverage in automobile insurance contracts; and
- Medicare or other governmental benefits, as permitted by law.

If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

Plan does not include any of the following:
- disability income protection coverage;
- the Texas Health Insurance Pool;
- workers' compensation insurance coverage;
- hospital confinement indemnity coverage or other fixed indemnity coverage;

- specified disease coverage;
- supplemental benefit coverage;
- accident only coverage;
- specified accident coverage;
- school accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis;
- benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
- Medicare supplement policies;
- a state plan under Medicaid;
- a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan; or
- other nongovernmental plan; or
- an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

Each contract for coverage shown above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

What is an Allowable Expense?
For purpose of COB, an Allowable Expense means a dental care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Insured is not an Allowable Expense.

How are benefits computed under COB?
In a Calendar Year, this 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 this 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 this Policy; and
  - under its terms, would compute its benefits after we compute the benefits under this Policy; and
- the rules shown in the "How are plans' benefits determined" section require that this 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, using the first of the following rules that apply:

- a Plan with no COB provision will be considered to pay its benefits before a Plan that contains such a provision, unless the provisions of both Plans state that the Plan with the COB provision pays its benefits before a Plan with no COB.
- 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. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare pays its benefits secondary to the Plan covering the person as a dependent and primary to the Plan covering the person as other than a dependent, then the order of benefits between the two Plans is reversed so the other Plan pays its benefits before the plan covering the person other than as a dependent.

- Unless there is a court decree stating otherwise, plans covering a dependent child must determine the order of benefits using the following rules that apply:
  - For a dependent child whose parents are married or are living together, whether or not they have ever been married, the Plan of the parent whose birthday falls earlier in the calendar year will be considered to pay its benefits before a Plan of the parent whose birthday occurs later in the calendar year. If both parents have the same birthday, the Plan that has covered the parent the longest will be considered to pay its benefits before the Plan that covered the parent the shorter time period.
  - 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 dental care expenses or dental care coverage and the Plan of that parent has actual knowledge of those terms, 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. This rule applies to plan years commencing after the Plan is given notice of the court decree.
    - if a court decree states that the parents have joint custody without specifying that one parent has responsibility for the dental care expenses or dental care coverage of the dependent child, benefits will be determined according to the birthday rule described above.
    - if there is no court decree allocating responsibility for the dependent child's dental care expenses or dental care coverage, the order of benefits for the child are as follows:
      - the Plan covering the custodial parent;
      - the Plan covering the custodial parent's spouse;
      - the Plan covering the noncustodial parent; then
      - the Plan covering the noncustodial parent's spouse.
  - For a dependent child covered by more than one Plan of individuals who are not the parents of the child, the birthday rule described above will be applied as if those individuals were the parents of the child.
  - For a dependent child who has coverage under either or both parents' Plans and has his or her own coverage as a dependent under a spouse's Plan, 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.
  - In the event the dependent child's coverage under the spouse's Plan began on the same date as the dependent child's coverage under either or both parents' Plans, the order of benefits must be determined by applying the birthday rule described above, considering the birthdays of the dependent child's parent(s) and the dependent child's spouse.
- 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; and
    - if a person whose coverage is provided under COBRA or continuation provided by state or other federal continuation law is covered under another Plan, the other Plan will be considered to pay its benefits before the Plan providing coverage under COBRA, state or other federal continuation law. If the other Plan does not contain this rule, then this rule shall not apply.
- If the preceding rules do not determine the order of benefits, the Allowable Expenses must be shared equally between the Plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid if it would have been considered to pay its benefits before the other Plan.

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.

8. CLAIM PROVISIONS

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

Any person who claims benefits under this 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 this 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 this Policy according to the COB provision is made under any other Plan, we have the right to pay that amount to the organization that made such payment. That amount will then be treated as though it were a benefit paid under this Policy. We will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

What if we overpay a claim?
If a payment made under this 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 persons it has paid or for whom it has paid. Or, we may recover the excess from any other person or organization that may be responsible for the benefits or services provided for an Insured. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

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;
- School Recess – up to 3 months;
- Vacation – based on your Employer's policy, not to exceed 3 months.

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

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

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

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

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

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

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

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

10. CONTINUITY OF COVERAGE

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

What if you are not Actively at Work when your Employer replaces the Prior Plan with this Policy?
You and your Dependents will be insured under this Policy if you are not Actively at Work on September 1, 2018 if:

- you were insured under the Prior Plan on the day before the Policy Effective Date;
- 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 this Policy and you are Actively at Work?
Your Spouse or Dependent Child will be insured under this Policy on September 1, 2018 if:

- your Spouse or Dependent Child was insured under your Employer's Prior Plan on the day before the Policy Effective date;
- 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 this Policy's Eligibility Waiting Period.

We will waive the Benefit Waiting Period for any Insured who was covered under the Prior Plan on the day before the Effective Date of this Policy.

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

Are benefits payable for Treatment you started before the effective date of this 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 this Policy, benefits for that Insured may be payable under the terms of this 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 he/she was insured under this Policy; and
- if the Prior Plan had no extension of benefits provision, benefits under this 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 this 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 this Policy becomes effective, we will reduce an Insured's Deductible under this Policy by any amount of Covered Dental Expenses that are Incurred in the Calendar Year in which this Policy becomes effective and applied toward the Prior Plan's deductible for such year.

An Insured's Deductible under this Policy cannot be reduced unless we receive the deductible information of the Prior Plan.

11. GENERAL PROVISIONS

AGENCY

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

ALTERATION

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

ASSIGNMENT

Can benefits be assigned?
You can assign benefits to a provider. You cannot assign any other interest in the Policy unless we agree in Writing to such an assignment. We do not assume any responsibility for the validity or sufficiency of any assignment.

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, or the Employer:

- 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

ENTIRE CONTRACT

What is the entire contract?
The following are incorporated in and made part of this Policy:

- any Policy amendments, endorsements or riders;
- the application of the Policyholder;
- the certificate(s); and
- any certificate amendments, endorsements or riders.

This Policy is the entire contract.

INCONTESTABILITY

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

LEGAL PROCEEDINGS

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

- until 61 days after Proof has been given; nor
- after the third anniversary after the time proof of claim is required.

LIMIT OF PREMIUM REFUNDS

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

MISSTATEMENT OF FACTS

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

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

NON-PARTICIPATING

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

11. GENERAL PROVISIONS

PREMIUMS

When are premiums due?
The premiums are due under this Policy on each premium due date and are based upon the premium rates in effect for the benefits provided. The premiums due are the sum of the monthly premiums for all persons insured for all benefits.

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 your Employer regarding the refund of premiums due, if any.

What is the notice for premium increases?
We will provide written notification of any increases in the premium rates to the Policyholder at least 60 days prior to the effective date of the increase. Premium rate increases may take effect on an earlier date when both the Policyholder and we agree.

What is the grace period?
The grace period is the 31-day period of time following the premium due date during which premium payment may be made. If the Policyholder does not pay the required premium before the end of the grace period, this Policy will automatically cease at the end of the grace period. If the Policyholder gives us advance written notice that this Policy will cease on an earlier date, then this Policy will cease on that date; but no such termination will take effect during any period for which the required premium has been paid to us.

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

REIMBURSEMENT

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

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

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

STATEMENTS

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

TIME PERIODS

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

SUN LIFE ASSURANCE COMPANY OF CANADA

Group Dental Certificate

Non-Participating