

E-Z Choice Dental

E-Z Choice Dental Insurance Provides:

- Coverage available to all industries with 3 to 24 lives
- Choice of Four Plans to fit your needs – Platinum, Gold, Silver or Brass – with a PPO Option where available
- Ability to go to a dentist of choice, or a network provider, where PPO is available
- \$50 Calendar Year Deductible waived for Preventive Services under All Plans
- Calendar Year Maximums up to \$1,500
- Orthodontic Services – Available w/Platinum Plan
 - Only for Children to Age 19
 - Lifetime Benefit: \$1,200; Calendar Year Maximum: \$500
- Optional Vision Coverage for groups with as few as 3 lives

E-Z Choice Dental

Benefits and Features	Brass Plan	Silver Plan	Gold Plan	Platinum Plan
Type I Preventive Coverage ¹	100% – deductible waived			
Type II Basic Coverage ¹	80% – subject to deductible			
Type III Major Coverage ¹	Unavailable	50% – subject to deductible, 12 month Waiting Period ² and \$500 Annual Maximum	50% – subject to deductible, 12 month Waiting Period ²	
Type IV Orthodontic Coverage ¹ (for eligible dependent children)	Unavailable			50% – subject to 24 month Waiting Period and maximums of \$500 per calendar year and \$1,200 lifetime
Annual Deductible	\$50 per person to a family maximum of \$150 annually			
Calendar Year per Person Maximum Benefit	\$1,000	\$1,200	\$1,200	\$1,500
Pre-Determination Limit	\$500			
PPO Option	Yes – subject to network availability			
Coordination of Benefits w/Other Plans	Yes, allowing reimbursement up to a maximum of 100% of the “allowable charges”			
Optional Vision Benefits ³	Yes, covering exams, lenses, frames and contact lenses			
Underwriting Requirements	Brass Plan	Silver Plan	Gold Plan	Platinum Plan
Group Size	3-24 employees			
Employee Eligibility	30 hours per week			
Employee Dependent Coverage	Yes			
Contributions	Employers pay all or part of premium			

¹ Covered expenses are limited to the usual and customary charges. The usual and customary charge is the amount standardly charged by most dental offices in the locality where the service is rendered.

² Waiting Period may be waived if employer’s existing dental plan included comparable coverage for Type III services at initial enrollment. This will only apply to employees who would have been eligible under the employer’s prior plan.

³ Benefits payable according to a schedule and subject to a \$50 per person, lifetime deductible.

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Dental Preferred Provider Organization Plan Option

Dental Preferred Provider Network

Delivering cost-efficient, quality dental services is the goal of our network of dental professionals. In exchange for participation in our growing network of selected dentists, these licensed and board-certified or board-eligible dentists have agreed to discounted fees. Through the use of Preferred Providers, your employees and their covered dependents will be reimbursed at a higher level of coinsurance than if they were to seek services from an out-of-network provider.

Note: Dental Preferred Provider Organization (PPO) Plans are not available in all areas.

Dental Preferred Provider Plan Coinsurance Amounts¹

Service Type	Brass Plan		Silver Plan		Gold Plan		Platinum Plan	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Type I	100%	90%	100%	90%	100%	90%	100%	90%
Type II	90%	60%	90%	60%	90%	60%	90%	60%
Type III	Not Covered		60%	40%	60%	40%	60%	40%
Type IV	Not Covered		Not Covered		Not Covered		50%	40%

¹ Percentage of Covered Expense payable after any applicable deductible and subject to plan maximums.

An example of how it works is shown below.

Example Assumptions: Silver Plan, Deductible satisfied, 90% coinsurance for In-Network Provider Services, 60% coinsurance level for Out-of-Network Provider Services.

	In-Network Provider	Out-of-Network Provider
Provider's Normal Charge	\$200	\$200
Discounted Fee Schedule Amount	\$150	Not Applicable
Covered Expense	\$150	\$200 ²
Coinsurance	90%	60%
Amount Paid under E-Z Choice Dental	\$135	\$120
Patient Out-of-Pocket Expense	\$15	\$80

² Maximum allowable covered expense based on usual & customary charge

Optional Vision Coverage

Vision benefits, available with any dental plan, are paid based on the following schedule, subject to a lifetime all services deductible and limited to either one pair of contacts or one pair of lenses and/or frames per calendar year.

Description	Maximum Allowance
Vision analysis conducted by an M.D.	\$75.00
Vision analysis conducted by an O.D.	\$60.00
Single vision lens	\$18.75
Single vision lenses	\$37.50
Bifocal lens	\$35.00
Bifocal lenses	\$70.00
Trifocal lens	\$45.00
Trifocal lenses	\$90.00
Lenticular lens	\$56.25
Lenticular lenses	\$112.50
One contact lens	\$25.00
Two contact lenses	\$50.00
Frames	\$50.00

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Dental Services Covered By Procedure Type

	Brass Plan	Silver Plan	Gold Plan	Platinum Plan
<p>Oral exams – 1 in 6 consecutive months</p> <p>Full mouth/panoramic x-rays – 1 per 60 months</p> <p>Bitewing x-rays – 1 set per 12 consecutive months up to a maximum of 4 films</p> <p>Intraoral x-rays</p> <p>Arthrograph and other TMJ films</p> <p>Periapical x-rays – 4 films per 12 consecutive months</p> <p>Prophylaxis – 1 in 6 consecutive months</p> <p>Fluoride treatment – for children up to age 16, 1 in 12 consecutive months</p> <p>Space maintainers – for children up to age 16, allowance includes all adjustments within 6 months of installation</p>	Type I			
<p>Palliative treatment</p> <p>Extraoral x-rays</p> <p>Restorative – amalgam, synthetic or plastic fillings</p> <p>Stainless steel crowns – for deciduous teeth</p> <p>Recements to inlays, crowns and bridges</p> <p>Repairs to dentures – limited to repairs or adjustments done more than 12 months after initial insertion</p> <p>Simple oral surgery – simple extractions and biopsies</p>	Type II			
Non-surgical periodontal procedures – scaling and root planing	Type II	Type III	Type II	Type II
Endodontics	Type II	Type III	Type III	Type II
<p>Major periodontal surgery – 1 surgical procedure per area of mouth per 36 months</p> <p>Anesthesia, including IV sedation – eligible as separate expense only when required for extraction of impacted teeth</p> <p>Oral surgery – impactions, alveoloplasty, vestibuloplasty, sinusotomy, residual root removal, incision and drainage</p> <p>Prosthetics – dentures and bridges</p> <p>Restorative – crowns, inlays, onlays</p> <p>Relines, rebases and adjustments – adjustments limited to service dates more than 12 months after installation. Relines are limited to 1 per 24 months and limited to service dates more than 12 months after installation</p>	Not Covered	Type III	Type III	Type III
<p>Cephalometric x-ray – 1 in any two year period</p> <p>Orthodontic treatment – limited to malocclusions as determined by us</p> <p>Study models – 1 set of study models per covered person</p>	Not Covered	Not Covered	Not Covered	Type IV

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General Plan Information

Eligibility

Employer Eligibility: Employers with 3 to 24 employees, subject to our standard underwriting guidelines.

Employee Eligibility: For an employee to be eligible, he or she must:

- Have at least 30 days continuous service, except for minor interruptions of not more than a total of five days, and;
- Perform all the duties of his or her occupation on a full-time basis (30 or more hours per week).

Dependent Eligibility: An employee's lawful spouse and dependent unmarried children, to age 19 years, 25 if a full-time student at an accredited college or school (subject to individual state law).

Participation

The following minimum participation requirements must be met:

Number of Eligible Employees	Minimum to be Insured
3 to 5	All
6 to 9	All but one
10 to 24	75% of all eligible employees

If employees do not contribute toward the cost, there must be 100% employee participation.

To cover dependents, a minimum of 75% of employees with eligible dependents must participate.

Employees who decline coverage for Dental because they have other coverage through a spouse's plan will not be considered eligible employees when determining minimum participation.

Effective Date

E-Z Choice Dental may be effective on the first or the 15th day of the month provided that the submission (E-Z Choice Request for Participation & Enrollment Form and other pertinent materials as indicated on the form) is postmarked no later than five business days after the chosen effective date.

Insurance for new employees will become effective on the later of the first day of the month following 30 days of continuous employment or the Waiting Period selected by the employer.

Rate Guarantee

Rate tables are guaranteed for 12 months after their initial effective date. Rates for firms moving from one industry (Standard Industry Classification code) or ZIP code area to another will change on the premium due date. We will notify employers in writing at least 31 days (subject to individual state law) before changing premium rate tables.

Late Entrant: If any employee application is received more than 31 days after a person becomes eligible, that person will be considered a "Late Entrant." A "Late Entrant" shall be entitled to coverage of Type I only covered expenses during his/her first 12 months of continuous coverage. After 12 months, a "Late Entrant" will be entitled to coverage of Types I and II only covered expenses for the following 12 months. After 24 months of coverage, a "Late Entrant" is entitled to full benefits.

Contribution Options

There are three ways to pay for E-Z Choice Dental employee and dependent coverage:

- The employer can pay 100% of the premium. If so, all eligible employees must be insured.
- The employee can pay 100% of the premium.
- The cost can be shared between employer and employees.

Dental Exclusions & Limitations

Covered expenses will not include and no benefits will be paid (nor will such expenses count toward meeting the Deductible Amount) for:

- Removal of asymptomatic wisdom teeth;
- Any treatment which is for cosmetic purposes (composites on molar teeth and facings on crowns or pontics behind the second bicuspid are considered cosmetic);
- The replacement of lost or stolen appliances;
- Initial placement of dentures or bridges which replace any teeth missing prior to the person's effective date of coverage under this plan, including congenitally missing teeth. (This exclusion will not apply if the prosthesis replaces a functioning natural tooth extracted while the person is covered under this plan.);
- Replacement of bridges unless the bridge is more than 10 years old and cannot be made serviceable;
- Replacement of full or partial dentures unless the prosthetic appliance is more than 10 years old and cannot be made serviceable;
- Replacement of crowns, inlays or onlays unless the prior placement is more than 10 years old and cannot be made serviceable;
- Appliances, services or procedures relating to (i) the change or maintenance of vertical dimension; (ii) restoration of occlusion; (iii) splinting; (iv) correction of attrition or abrasion; (v) bite registration or (vi) bite analysis;
- Services provided for any type of temporomandibular joint (TMJ) dysfunctions, muscular, skeletal deficiencies involving TMJ or related structures, myofascial pain (subject to individual state law);
- Orthognathic surgery;
- Prescribed drugs, pre-medication or analgesia;
- Sealants or any instruction for diet, plaque control and oral hygiene;
- Charges for: implants of any type, and all related procedures, removal of implants, precision or semi-precision attachments, denture duplication, over-dentures and any associated surgery, or other customized services or attachments;
- Cast restorations and crowns for teeth that are not broken down by extensive decay or accidental injury or for teeth that can be restored by other means;
- Temporary crowns and prosthetics (bridges and dentures);
- (For Brass Plan only) Periodontal major surgery, inlays, crowns and prosthetics (dentures and bridges);
- Services or supplies not shown on the List of Covered Dental Expenses;
- Any procedure begun after the Covered Person's insurance under the policy terminates, or for any prosthetic dental appliance finally installed or delivered more than 30 days after the Covered Person's insurance under the Policy terminates;
- Any procedure begun or appliance installed before a Covered Person became insured under the Policy;
- Any procedure which is not necessary as determined by us; does not offer a favorable prognosis; does not meet accepted standards of care; or does not have uniform professional endorsement or which is experimental in nature;
- Services or supplies rendered by someone who is related to a Covered Person by blood (sibling, parent, child), marriage, or is normally a member of the Covered Person's household;
- Any procedure, service or supplies which are included as covered medical expenses under a medical expense benefit plan;
- Expenses compensable under Workers' Compensation or Employers' Liability Laws;
- Expenses provided or paid for by any governmental program or law, except as to charges which the person is legally obligated to pay.

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Vision Coverage Exclusions & Limitations

Covered vision expenses will not include and no benefits will be paid (nor will such expenses count toward meeting the Deductible Amount) for:

- Any procedures, services or supplies which are included as covered medical expenses under a medical expense benefit plan;
- Orthoptics, vision training, subnormal vision aids;
- Plain or prescription sunglasses, special purpose vision aids, or additional charges resulting from customized or designer features;
- Medical or surgical treatment of the eyes;
- Replacement of lost or broken lenses and/or frames;
- Duplicated glasses, lenses or frames thereof;
- Services or material not listed in the Schedule of Insurance, or which are not necessary to restore normal visual acuity;
- Services or supplies rendered by someone who is related to a Covered Person by blood (sibling, parent, child), marriage, or is normally a member of the Covered Person's household;
- Charges resulting from an accidental bodily injury arising out of or in the course of employment for wages or profit, or from any sickness for which benefits are provided under any Workers' Compensation Law or any similar legislation.

Coverage is provided for replacement of existing lenses only when required by a change in prescription, and replacement of frames only when existing frames are not compatible with new lenses.

Contact lenses will be covered only if there is a change in prescription and refraction analysis is performed.

Lenses, Frames and Contacts are limited to either one pair of contacts OR one pair of lenses and/or frames per calendar year.

Termination

Employee coverage will cease on the earliest of the following:

- the last day of the calendar month that the employee is no longer actively at work.
- the last day of the calendar month that the employee ceases to be in a class of employees who are eligible for such coverage.
- the day the employee fails to make any required contribution.
- the day the employer's participation under the policy is terminated.
- when participation drops below three eligible employees.

We reserve the right to decline any coverage which does not meet our underwriting guidelines, even if not previously published. Our standard benefits, exclusions and limitations are described in this brochure; where state laws dictate otherwise, our benefits, exclusions and limitations are in compliance with those laws. Also, benefits are subject to state availability. Please check with the home office to verify that this product is approved in the state where the proposed group is located. For more information about any of our products or services, please contact your group insurance advisor or your Sun Life Financial Group Representative.

Group insurance policies are underwritten by Genworth Life and Health Insurance Company (Windsor, CT) in all states under Policy Form Numbers GP-A and GP-D (or appropriate state edition with respect to Stop-Loss policies). Product offerings may not be available in all states.

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