

Sun Life Dental Care

Individual Enrollment

Thank you for your interest in the Sun Life Dental Program. Sun Life Dental Care is a managed dental plan that arranges for comprehensive dental services through their contracted panel of dentists conveniently located throughout Colorado. The enclosed package should provide you with everything necessary to fully review the program and become a plan member.

Sample Benefits of Assurant Dental Care Plan

Routine Office Visit	Low Co-payment
Comprehensive Oral Evaluation	No Charge
X-Ray- Intraoral, Comp., Series, Incl. Bitewing	No Charge
Topical Application of Fluoride (Child)	No Charge
Fillings	Low Co-payment
Crowns and Bridges	Low Co-payment

Special features include No Deductibles, No Claim Forms, No Maximum Limits on Benefits, No Pre-Existing Dental Problems Excluded, No Referral required for specialists, Orthodontia Included, and a Worldwide Emergency Benefit.

Vision Benefit
Included

Low Monthly Cost

Member Only	\$12.15
Member + 1	\$20.02
Member & Family	\$31.02



How to Enroll

- Step 1:** You may enroll online or complete all sections of the enclosed enrollment form. To enroll online: <https://www.natbenco.com/prepaid-dental-application.html>
- Step 2:** You must select a dentist from the Sun Life website: http://sunlife.go2dental.com/member/dental_search/srchinp.cgi?plan_number=24 (Select Colorado then enter your zip code) or call Sun Life at 1-800-443-2995 for a list of dentists in your area. Record the dentist's Facility ID number on the enrollment form in the space provided. Application cannot be processed if you do not select a dentist.
- Step 3:** After completing and signing the enrollment form, complete the payment authorization form and mail them to:

National Benefits Consultants
7395 E. Peakview Ave.
Centennial, CO 80111

Enrollment form with payment must be received by the 20th of the month in order to begin coverage on the 1st day of the following month. When your enrollment is processed, membership confirmation will be sent to your e-mail address. You may make an appointment with your selected dentist at anytime after your effective date of coverage.

Questions: Sun Life Dental Care: 1-800-443-2995
 National Benefits- billing administration: 1-720-488-9892

SUMMIT PLAN

COLORADO Sample Copayment Schedule

This dental plan is underwritten by United Dental Care of Colorado, Inc.

1. Plan Dentist Services

The dental services listed on the Copayment Schedule below are covered only when provided by the Member's selected Plan Dentist. Dental services that do not appear on this list are not covered by the plan. Members will be responsible for paying the amount listed in the "Member Copayment" column at the time the service is received, or in accordance with the Plan Dentist's billing procedures.

Except in the case of covered dental emergency services, payment for all services received from a Non-Plan Dentist will be the responsibility of the Member.

2. Plan Specialist Services

Should Member require dental services that his selected Plan Dentist is unable to provide, he may obtain those services from a Plan Specialist at a discounted rate. No referral is needed from the selected Plan Dentist in order for Member to obtain services from Plan Specialist. There is no applicable copayment schedule for Plan Specialist services. Instead, the following discounts will apply. A 15% discount off that Plan Specialist's normal retail charges will be applied to charges obtained from a Plan Specialist who is an Endodontist. A 25% discount off the Plan Specialist's normal retail charges will be applied to all other services (including orthodontic services) received from a Plan Specialist. Member will be responsible for paying the entire discounted charge at the time the service is received, or in accordance with the Plan Specialist's billing procedures. Members covered by a Specialty Benefit Amendment may have some specialty services covered by a copayment schedule. Please consult your Copayment Schedule with Specialty Benefits for complete details.

Except in the case of covered dental emergency services, payment for all services received from a Non-Plan Specialist will be the responsibility of the Member.

ADA Code	Plan Dentist Treatment	Member Copayment
Appointments		
999	Routine Office Visit	5.00
120	Periodic Oral Evaluation	No Charge
150	Comprehensive Oral Evaluation	No Charge
140	Limited Oral Evaluation - Problem Focused (emergency office visit, normal hours)	20.00
9440	Emergency Office Visit (after regularly scheduled office hours)	40.00
9999	Missed Appointment without 24-Hour Notice	20.00
Diagnostic Dentistry		
210	X-Ray - Intraoral, Complete Series, Including Bitewings	No Charge
220	X-Ray - Intraoral, Periapical, First Film	No Charge
230	X-Ray - Intraoral, Periapical, Each Additional Film	No Charge
240	X-Ray - Intraoral, Occlusal Film	No Charge
250	X-Ray - Extraoral, First Film	No Charge
260	X-Ray - Extraoral, Each Additional Film	No Charge
270	X-Ray - Bitewing Single Film	No Charge
272	X-Ray - Bitewing Two Films	No Charge
274	X-Ray - Bitewing Four Films	No Charge
330	X-Ray - Panoramic Film	No Charge
415	Bacterial Studies	No Charge
425	Caries Susceptibility Tests	No Charge
460	Pulp Vitality Tests	No Charge
Preventive Dentistry		
1110	Routine Prophyl/Cleaning - Adult (once every 6 mos.)	8.00
1120	Routine Prophyl/Cleaning - Child up to age 18 (once every 6 mos.)	6.00
1203	Topical Application of Fluoride - Child up to age 18 (Prophyl/cleaning not included)	No Charge

ADA Code	Plan Dentist Treatment	Member Copayment
1310	Nutritional Counseling	No Charge
1330	Oral Hygiene Instruction	No Charge
1351	Application of Sealant, Per Tooth	8.00
1510	Space Maintainer (Fixed) - Unilateral*	75.00
1515	Space Maintainer (Fixed) - Bilateral*	75.00
1520	Space Maintainer (Removable) - Unilateral*	75.00
1525	Space Maintainer (Removable) - Bilateral*	75.00
1550	Recement Space Maintainer	8.00
1999	Additional Routine Prophyl/Cleaning	25.00
(Routine cleaning does not apply to patients with periodontal disease)		
Restorative Dentistry (Fillings/Crowns)		
2110	Amalgam - One Surface, Primary	10.00
2120	Amalgam - Two Surfaces, Primary	15.00
2130	Amalgam - Three Surfaces, Primary	20.00
2131	Amalgam - Four or More Surfaces, Primary	25.00
2140	Amalgam - One Surface, Permanent	15.00
2150	Amalgam - Two Surfaces, Permanent	20.00
2160	Amalgam - Three Surfaces, Permanent	25.00
2161	Amalgam - Four or More Surfaces, Permanent	30.00
2330	Resin Filling - One Surface, Anterior	20.00
2331	Resin Filling - Two Surfaces, Anterior	25.00
2332	Resin Filling - Three Surfaces, Anterior	35.00
2335	Resin Filling - Four or More Surfaces, Anterior	65.00
2385	Resin Filling - One Surface, Posterior, Permanent	40.00
2386	Resin Filling - Two Surfaces, Posterior, Permanent	55.00
2387	Resin Filling - Three or More Surfaces, Posterior, Permanent	70.00
2510	Inlay - Metallic, One Surface*	120.00
2520	Inlay - Metallic, Two Surfaces*	160.00
2530	Inlay - Metallic, Three or More Surfaces*	225.00
2543	Onlay - Metallic, Three Surfaces*	200.00
2544	Onlay - Metallic, Four or More Surfaces*	205.00
2610	Inlay - Porcelain/Ceramic, One Surface*	200.00
2620	Inlay - Porcelain/Ceramic, Two Surfaces*	205.00
2630	Inlay - Porcelain/Ceramic, Three or More Surfaces*	210.00
2740	Crown - Porcelain/Ceramic*	245.00
2750	Crown - Porcelain Fused to High Noble Metal*	245.00
2751	Crown - Porcelain Fused to Base Metal*	245.00
2752	Crown - Porcelain Fused to Noble Metal*	245.00
2790	Crown - Full Cast High Noble Metal*	245.00
2791	Crown - Full Cast Base Metal*	245.00
2792	Crown - Full Cast Noble Metal*	245.00
2810	Crown - 3/4 Cast Metallic*	245.00
2910	Recement Inlay	10.00
2920	Recement Crown	10.00
2930	Prefabricated Stainless Steel Crown - Primary Tooth	70.00
2940	Sedative Filling	15.00
2950	Core Buildup, Including Any Pins	30.00
2951	Pin Retention - Per Tooth in Addition to Restoration	12.00
2952	Cast Post and Core, in Addition to Crown*	90.00
2954	Prefabricated Post and Core, in Addition to Crown	80.00
2960	Labial Veneer (Laminate) - Chairside	260.00
2962	Labial Veneer (Porcelain Laminate) - Lab*	315.00

ADA Code	Plan Dentist Treatment	Member Copayment	ADA Code	Plan Dentist Treatment	Member Copayment
2980	Repair Crown*	20.00	5751	Reline Complete Lower Denture - Lab*	95.00
2999	Temporary Filling	15.00	5760	Reline Upper Partial Denture - Lab*	95.00
2999	Cosmetic Bleaching, Per Arch	150.00	5761	Reline Lower Partial Denture - Lab*	95.00
2999	Cosmetic Bleaching, Both Arches	300.00	5850	Tissue Conditioning - Upper Denture	20.00
			5851	Tissue Conditioning - Lower Denture	20.00
			5862	Precision Attachment, by Report*	100.00
	Endodontics (Root Canals)			Fixed Prosthodontics	
3110	Pulp Cap - Direct	15.00	6210	Pontic - Cast High Noble Metal, Per Unit*	245.00
3120	Pulp Cap - Indirect	15.00	6211	Pontic - Cast Base Metal, Per Unit*	245.00
3220	Pulpotomy	30.00	6212	Pontic - Cast Noble Metal, Per Unit*	245.00
3310	Root Canal - Anterior (excluding final restoration)	125.00	6240	Pontic - Porcelain Fused to High Noble Metal, Per Unit*	245.00
3320	Root Canal - Bicuspid (excluding final restoration)	150.00	6241	Pontic - Porcelain Fused to Base Metal, Per Unit*	245.00
3330	Root Canal - Molar (excluding final restoration)	210.00	6242	Pontic - Porcelain Fused to Noble Metal, Per Unit*	245.00
3346	Retreatment of Previous Root Canal Therapy - Anterior	250.00	6251	Pontic - Resin with Base Metal, Per Unit*	245.00
3347	Retreatment of Previous Root Canal Therapy - Bicuspid	325.00	6545	Resin Bonded Retainer, Per Unit*	140.00
3348	Retreatment of Previous Root Canal Therapy - Molar	400.00	6721	Crown - Resin with Base Metal, Per Unit*	245.00
3410	Apicoectomy - Anterior	155.00	6750	Crown - Porcelain Fused to High Noble Metal, Per Unit*	245.00
3421	Apicoectomy - Bicuspid, First Root	155.00	6751	Crown - Porcelain Fused to Base Metal, Per Unit*	245.00
3425	Apicoectomy - Molar, First Root	155.00	6752	Crown - Porcelain Fused to Noble Metal, Per Unit*	245.00
3426	Apicoectomy - Each Additional Root	100.00	6780	Crown - 3/4 Cast High Noble Metal, Per Unit*	245.00
3430	Retrograde Filling - Per Root	50.00	6790	Crown - Full Cast High Noble Metal, Per Unit*	245.00
3450	Root Amputation - Per Root	60.00	6791	Crown - Full Cast Base Metal, Per Unit*	245.00
3920	Hemisection (Including Any Root Removal), Not Including Root Canal Therapy	50.00	6792	Crown - Full Cast Noble Metal, Per Unit*	245.00
	Periodontics		6930	Recement Bridge	15.00
4210	Gingivectomy or Gingivoplasty, Per Quadrant	160.00	6940	Stress Breaker	75.00
4220	Gingival Curettage, Per Quadrant	65.00	6950	Precision Attachment	150.00
4260	Osseous Surgery, Per Quadrant	300.00	6980	Bridge Repair*	45.00
4320	Provisional Splinting Intracoronal	80.00	6999	Resin Bonded Bridge Pontic, Per Unit*	200.00
4321	Provisional Splinting Extracoronal	60.00		Oral Surgery	
4341	Periodontal Scaling and Root Planing, Per Quadrant	55.00	7110	Single Tooth Extraction	20.00
4355	Full Mouth Debridement (Complicated Cleaning)	40.00	7120	Each Additional Tooth Extraction, Per Visit	18.00
4910	Periodontal Maintenance Procedures	30.00	7130	Root Removal - Exposed Roots	25.00
4999	Periodontal Hygiene Instruction	No Charge	7210	Surgical Removal of Erupted Tooth	40.00
4999	Periodontal Charting for Planning Treatment of Periodontal Disease	12.00	7220	Removal of Impacted Tooth - Soft Tissue	55.00
	Removable Prosthodontics (Dentures)		7230	Removal of Impacted Tooth - Partial Bony	85.00
5110	Complete Upper Denture*	325.00	7240	Removal of Impacted Tooth - Complete Bony	125.00
5120	Complete Lower Denture*	325.00	7241	Removal of Impacted Tooth - Complete Bony, with Complications	145.00
5130	Immediate Upper Denture (Excluding Reline)*	325.00	7250	Surgical Removal of Residual Roots (Cutting Procedure)	55.00
5140	Immediate Lower Denture (Excluding Reline)*	325.00	7270	Tooth Reimplantation/Stabilization	100.00
5211	Partial Denture - Upper Resin Base, Including Clasps, etc.*	325.00	7281	Surgical Exposure, Per Tooth	80.00
5212	Partial Denture - Lower Resin Base, Including Clasps, etc.*	325.00	7310	Alveoloplasty in Conjunction With Extractions, Per Quadrant	70.00
5213	Partial Denture - Upper Cast Metal Framework/Acrylic Base*	325.00	7320	Alveoloplasty Not in Conjunction with Extractions, Per Quadrant	95.00
5214	Partial Denture - Lower Cast Metal Framework/Acrylic Base*	325.00	7470	Removal of Exostosis	100.00
5410	Adjust Complete Denture - Upper	15.00	7510	Incision and Drainage of Abscess - Intraoral	40.00
5411	Adjust Complete Denture - Lower	15.00	7910	Suture of Small Wound up to 5 cm.	85.00
5421	Adjust Partial Denture - Upper	15.00	7960	Frenectomy	90.00
5422	Adjust Partial Denture - Lower	15.00		Other Services	
5510	Repair Broken Complete Denture Base*	40.00	9220	General Anesthesia (first 30 minutes)	180.00
5610	Repair Resin Denture Base*	35.00	9230	Analgesia - Nitrous Oxide (per 30 minutes)	15.00
5620	Repair Cast Framework*	35.00	9240	IV Sedation	180.00
5630	Repair or Replace Broken Clasps	45.00	9310	Consultation Appt.	40.00
5640	Repair Broken Teeth - Per Tooth	45.00	9940	Occlusal Guards	120.00
5650	Add Tooth to Existing Partial Denture	45.00	9951	Occlusal Adjustment - Limited	30.00
5730	Reline Complete Upper Denture - Chairside	75.00	9952	Occlusal Adjustment - Complete	100.00
5731	Reline Complete Lower Denture - Chairside	75.00			
5740	Reline Upper Partial Denture - Chairside	75.00			
5741	Reline Lower Partial Denture - Chairside	75.00			
5750	Reline Complete Upper Denture - Lab*	95.00			

This is a Sample Member Copayment Schedule only. It is not an Evidence of Coverage. Please see the Group Dental Service Agreement and Evidence of Coverage, which determines all rights, benefits, and applicable Limitations and Exclusions.

Legend Series

Sample Copayment Schedule

For Specialty Benefit Amendment

How Your Specialty Benefit Amendment Works

Should you need the services of a dental care Specialist, you may do so without a referral from your Plan dentist.

If you use a Specialist who is a part of our provider network for a procedure listed below on the Specialty Benefit Amendment (SBA), you will simply pay the Member Copayment amount at the time of service. However, if the procedure is not listed on the SBA,

you will receive a 25% discount, including orthodontic services, (15% from Endodontists, includes root canal therapy) off of the Specialist's normal retail charges. Benefits under the Specialty Benefit Amendment are available only if you use a Specialist who is a part of our provider network.

No Annual Maximum!

There is no annual maximum for procedures performed by a Plan Specialist.

ADA Code	Plan Dentist Treatment	In Network Member Copayment
Appointments		
140	Limited Oral Evaluation – Problem Focused (emergency office visit, normal hours).....	25.00
150	Comprehensive Oral Evaluation.....	25.00
Endodontics (Root Canals)		
3320	Root Canal - Bicuspid (excluding final restoration).....	235.00
3330	Root Canal - Molar (excluding final restoration)	320.00
3346	Retreatment of Previous Root Canal Therapy - Anterior ...	335.00
3347	Retreatment of Previous Root Canal Therapy - Bicuspid ..	430.00
3348	Retreatment of Previous Root Canal Therapy - Molar.....	475.00
3410	Apicoectomy - Anterior	200.00
3421	Apicoectomy - Bicuspid, First Root.....	230.00
3425	Apicoectomy - Molar, First Root	265.00
3430	Retrograde Filling - Per Root.....	65.00
Periodontics		
4210	Gingivectomy or Gingivoplasty, Per Quadrant	225.00
4220	Gingival Curettage, Per Quadrant	90.00
4260	Osseous Surgery, Per Quadrant	390.00
4341	Periodontal Scaling and Root Planing, Per Quadrant	80.00
4355	Full Mouth Debridement (Complicated Cleaning).....	55.00
4381	Local Delivery Chemo Per Tooth.....	60.00

ADA Code	Plan Dentist Treatment	In Network Member Copayment
Oral Surgery		
7210	Surgical Removal of Erupted Tooth	60.00
7220	Removal of Impacted Tooth - Soft Tissue.....	80.00
7230	Removal of Impacted Tooth - Partial Bony	105.00
7240	Removal of Impacted Tooth - Complete Bony	150.00
7241	Removal of Impacted Tooth - Complete Bony, with Complications	160.00
7250	Surgical Removal of Residual Roots (Cutting Procedure) ...	60.00
7281	Surgical Exposure, Per Tooth	150.00
7310	Alveoplasty in Conjunction with Extractions, Per Quadrant.....	100.00
7320	Alveoplasty Not in Conjunction with Extractions, Per Quadrant.....	85.00
7470	Removal of Exostosis.....	220.00
7510	Incision and Drainage of Abscess – Intraoral.....	70.00
7960	Frenectomy	145.00
Other Services		
9240	IV Sedation.....	130.00

This is a Sample Member Copayment Schedule only. It is not an Evidence of Coverage. Please see the Group Dental Service Agreement (PDC-CO-0105), Evidence of Coverage (PDC-CO-0107) and Copayment Schedule (PDC-CO-0109), which determine all rights, benefits, and applicable Limitations and Exclusions.

Benefits provided by or underwritten by United Dental Care of Colorado, Inc.

VISION DISCOUNT SERVICES



ACCESS PLAN

Your dental plan includes a vision discount plan through Vision Service Plan (VSP). The vision plan includes discounts on exams (including contact lens exams) and the purchase of eyeglasses, sunglasses and other prescription eyewear when provided by VSP doctors. VSP is available for you and everyone covered on your dental plan!

Services Available from a VSP Doctor

- **Eye Exams** – 20% discount applied to VSP doctor's usual and customary fees for eye exams¹
- **Glasses** – 20% discount applied to VSP doctor's usual and customary fees for complete pairs of prescription glasses and spectacle lens options²
- **Contact Lenses** – 15% discount on VSP network doctor's contact lens exam fee.
- **Laser VisionCareSM** – VSP has contracted with many of the nation's laser surgery facilities and doctors, offering you a discount off PRK and LASIK surgeries, available through contracted laser centers

Other Valuable Features for You

- Immediate savings when using a VSP doctor
- You may use the discounts as often as you wish
- No waiting periods
- No deductibles
- No claim forms to fill out

How to Use VSP

Locate a VSP doctor near you. You may either use our Web-based doctor locator at www.vsp.com, or call VSP at **800.877.7195** to request a doctor listing.

Identify yourself as a VSP member and be prepared to provide the *enrolled member's* social security number when you make your appointment. (The VSP doctor will verify your eligibility and vision plan coverage, and will obtain authorization for services and materials. If you are not currently eligible for services, the VSP doctor is responsible for communicating this to you.)

Your fees are automatically reduced at the time of service – with no claim forms to fill out!

THIS VISION DISCOUNT PLAN IS NOT INSURANCE.

¹Note: Does not apply to contact lens services. See contact lens section for applicable discount.

²Discounts only offered through the VSP doctor who provided an eye exam within the last 12 months.

VSP Member Services Support: 800.877.7195
Visit our Web site at www.vsp.com

ENROLLMENT FORM
PLEASE PRINT CLEARLY IN BLUE OR BLACK INK

Group Name Metro State College of Denver			Group Number 915512	Effective Date		
<input type="checkbox"/> I apply for the following coverage for myself and dependents, as listed. Managed Care Plan <input type="checkbox"/> Summit						
Employee First Name	MI	Last Name	<input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /	Facility ID #	
Employee Street Address			City	State	Zip	
Employee Social Security Number						
Home Phone ()	Work Phone ()	Division/Department/Class		Date of Hire / /		
Dependents to be included for coverage:						
First Name	MI	Last Name (if different)	Relationship	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /	Facility ID#
				<input type="checkbox"/> M <input type="checkbox"/> F	/ /	
				<input type="checkbox"/> M <input type="checkbox"/> F	/ /	
				<input type="checkbox"/> M <input type="checkbox"/> F	/ /	
				<input type="checkbox"/> M <input type="checkbox"/> F	/ /	
Check any boxes that apply and follow instructions						
<input type="checkbox"/> Are you covering more than three children? Please continue listing on additional Enrollment Forms. <input type="checkbox"/> Is the address of any child different than the member's? Show that child's name & address on the back of this form. <input type="checkbox"/> Are you requesting coverage for a dependent child other than a son or daughter? Forward legal custody paper. <input type="checkbox"/> Are you requesting coverage for dependent child over age 19 that is NOT a full time student? Furnish proof of incapacity within 31 days of the Effective Date.						
<input type="checkbox"/> I elect not to have coverage for myself or my dependents and I hereby waive coverage under the above mentioned plans.						
Signature: _____ Date: _____						
To the best of my knowledge and belief, each of the statements and answers supplied in this form is complete and true, and they constitute the sole basis for, and are the inducement for, the issuance of any coverage. Please read the following and sign below.						
The Managed Care Plan is underwritten by United Dental Care of Colorado, Inc. and administered by Fortis Benefits Insurance Company I hereby apply for membership in this dental Plan for myself and for any eligible dependents listed above. I authorize the [Group] named above to make deductions, if any, required as my contribution. I agree, for myself and for any eligible dependents listed, to abide by the rules and regulations of the Plan and the terms and conditions of the Group Dental Service Agreement. I authorize any licensed dentist, physician, hospital or other health care provider to furnish the Plan with any required dental or medical information, as permitted by law about myself and any eligible dependents listed. I represent the information provided is true and correct to the best of my knowledge. I further understand that my coverage and benefits may be affected by failure to provide complete and accurate information. I will promptly advise the Plan and my [Group] of any changes in this information.						
Signature: _____ Date: _____						

National Benefits Consultants

7395 E. Peakview Ave. Centennial, CO 80111

Fax: 720-488-9893

E-mail: Info@NatBenCo.com

CREDIT CARD AUTHORIZATION

Customer Information

Contact Name: _____

Telephone: _____

Email: _____

Address: _____

Country: _____

Please fill out, scan and send completed form via:

Fax:
435-268-3603

Mail:
7395 E. Peakview Ave.
Centennial, CO 80111

Email:
Info@NatBenCo.com

Any information sent via E-Mail or Fax is not secure and is being transmitted at sender's own risk.

Credit Card Account

Account Type: _____ VISA _____ MASTERCARD

Account Number:

Expiry Date:

Security Code:

Cardholder Name: _____

Address: _____

Frequency: Monthly _____ Annually _____

It is the Customer's responsibility to inform National Benefits of any changes to the billing address, expiration date and/or changes to the card holder's name of credit card account provided. Any information provided in this form will be used for the completion of this transaction only, and will be destroyed after completing the purchase.

Authorization

I authorize National Benefits Consultants to debit the credit card account provided above for the purchase of product by the above Customer. I also understand that this authorization will remain valid for monthly pay members only, until I cancel such authorization in writing.

Authorized Signature: _____ Date: _____