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

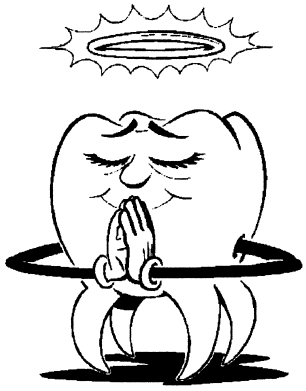
Routine Office Visit	Low Co-payment
Comprehensive Oral Evaluation	No Charge
X-Ray- Intraoral, Comp., Series, Incl. Bitewing	No Charge
Topical Application of Fluoride (Child)	No Charge
Fillings	Low Co-payment
Crowns and Bridges	Low Co-payment

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
P.O. Box 370528
Denver, CO 80237-0528

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 Prophy/Cleaning - Adult (once every 6 mos.)	8.00
1120	Routine Prophy/Cleaning - Child up to age 18 (once every 6 mos.)	6.00
1203	Topical Application of Fluoride - Child up to age 18 (Prophy/cleaning not included)	No Charge
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 Prophy/Cleaning (Routine cleaning does not apply to patients with periodontal disease)	25.00
	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

*Members are responsible for additional lab fees for these services.

See Other Side

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

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.

*Members are responsible for additional lab fees for these services.

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	Alveoloplasty in Conjunction with Extractions, Per Quadrant	100.00
7320	Alveoloplasty 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 exams[1]
- **Glasses** – 20% discount applied to VSP doctor's usual and customary fees for complete pairs of prescription glasses and spectacle lens options[2]
- **Contact Lenses** – 15% discount on VSP network doctor's contact lens exam fee.
- **Laser VisionCare**[SM] – 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.

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

VSP

ENROLLMENT FORM

PLEASE PRINT CLEARLY IN BLUE OR BLACK INK

Group Name	Group Number	Effective Date
Metro State College of Denver	915512	

❑ **I apply for the following coverage for myself and dependents, as listed.**

Managed Care Plan

❑ Summit

Employee First Name	MI	Last Name	❑ M ❑ 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	Date of Birth	Facility ID#
				❑ M ❑ F	/ /	
				❑ M ❑ F	/ /	
				❑ M ❑ F	/ /	
				❑ M ❑ F	/ /	

Check any boxes that apply and follow instructions

- ❑ Are you covering more than three children? **Please continue listing on additional Enrollment Forms.**
- ❑ Is the address of any child different than the member's? **Show that child's name & address on the back of this form.**
- ❑ Are you requesting coverage for a dependent child other than a son or daughter? **Forward legal custody paper.**
- ❑ 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.**

❑ **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

P.O. Box 370528 Denver, CO 80237-0528
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:
720-488-9893

Mail:
P.O. Box 370528
Denver, CO 80237-0528

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 and continue until I cancel such authorization in writing.

Authorized Signature: _____ Date: _____