

Dental

®

COMMONLY COVERED

- ✓ Exams and cleanings
- ✓ X-rays
- ✓ Fillings
- ✓ Tooth extractions
- ✓ Child braces

► PROTECTS YOUR SMILE.

You can feel more confident with a dental plan that encourages routine cleanings and checkups. A dental plan helps protect your teeth for a lifetime.

► PREVENTS OTHER HEALTH ISSUES.

Just annual preventive care alone can help prevent other health issues such as heart disease and diabetes. Many plans cover preventive services at or near 100% to make it easy for you to use your dental benefits.

► LOWERS OUT-OF-POCKET EXPENSES.

Seeing an in-network dentist can reduce your fees approximately 30% from their standard fees. Add the benefits of your coinsurance to that and things are looking good for your wallet.

Your employer is offering you a choice of two dental plans. Please review the information for both the basic and enhanced plans. Then, choose the one plan that best fits your needs.

HOW CAN DENTAL CARE HELP?

Gum disease may cause tooth loss and may be linked to other health problems such as heart disease and diabetes.¹

Brushing, flossing, and seeing your dentist regularly can help reduce the impact of gum disease.²

What's covered (basic plan)

CALENDAR YEAR MAXIMUM	IN-NETWORK	OUT-OF-NETWORK
Type I, II, III (Preventive, Basic and Major Services)	\$1,250 per person	\$1,250 per person
Type IV Ortho Service	\$1,000 lifetime per child	\$1,000 lifetime per child

Services performed by in-network and out-of-network providers share the same deductible application and benefit maximums.

CALENDAR YEAR DEDUCTIBLE

PROCEDURE	IN-NETWORK	OUT-OF-NETWORK
Type I Preventive Services	N/A	N/A
Type II, III (Basic and Major Services)	\$50 individual/\$150 family	\$50 individual/\$150 family
Type IV Ortho Services	N/A	N/A

THE PLAN PAYS THE FOLLOWING PERCENTAGE FOR PROCEDURES

PROCEDURE	IN-NETWORK	OUT-OF-NETWORK
Type I Preventive Services	80%	80%
Type II Basic Services	80%	80%
Type III Major Services	50%	50%
Type IV Ortho Services	50%	50%

SERVICES

Type I Preventive Dental Services, including:

- Oral evaluations – 2 in any calendar year
- Routine dental cleanings – 2 in any calendar year (frequency combined with periodontal maintenance)
- Fluoride treatment – 1 in any 6 month period. *Only for children under age 19*
- Sealants – no more than 1 per tooth in any 36 month period, only for permanent molar teeth. *Only for children under age 14*
- Space maintainers – *only for children under age 19*
- Bitewing x-rays – 1 in any 12 month period
- Intraoral complete series x-rays – 1 in any 60 month period
- Genetic test for susceptibility to oral diseases

Type II Basic Dental Services, including:

- New fillings
- Simple extractions, incision and drainage
- Surgical extractions of erupted teeth, impacted teeth, or exposed root
- Biopsy (including brush biopsy)
- Endodontics (includes root canal therapy) – 1 per tooth in any 24 month period
- General anesthesia/IV sedation – medically required
- Minor gum disease (non-surgical periodontics)

- Scaling and root planing – 1 in any 24 month period per area
- Periodontal maintenance – 2 in any calendar year (frequency combined with routine dental cleanings)
- Localized delivery of antimicrobial agents
- Major gum disease (surgical periodontics)

Type III Major Dental Services, including:

- Dentures and bridges – subject to 5 year replacement limit
- Stainless steel crowns – *only for children under age 19*
- Inlay, onlay, and crown restorations – 1 per tooth in any 5 year period
- Dental implants – subject to 5 year replacement limit

Type IV Ortho Services, including:

- Orthodontic treatment is limited to your dependent children up to age 26

Waiting Periods

For a complete description of services and waiting periods, please review your plan document. If you were covered under your employer's prior plan the wait will be waived for any type of service covered under the prior plan and this plan.

- No waiting period for preventive, basic or major services
- 12 months for orthodontic services

What's covered (enhanced plan)

Good news! Your plan covers routine services like cleanings and exams at **100%**.

CALENDAR YEAR MAXIMUM	IN-NETWORK	OUT-OF-NETWORK
Type I, II, III (Preventive, Basic and Major Services)	\$2,000 per person	\$2,000 per person
Type IV Ortho Service	\$1,000 lifetime per child	\$1,000 lifetime per child

Services performed by in-network and out-of-network providers share the same deductible application and benefit maximums.

CALENDAR YEAR DEDUCTIBLE

PROCEDURE	IN-NETWORK	OUT-OF-NETWORK
Type I Preventive Services	N/A	N/A
Type II, III (Basic and Major Services)	\$50 individual/\$150 family	\$50 individual/\$150 family
Type IV Ortho Services	N/A	N/A

THE PLAN PAYS THE FOLLOWING PERCENTAGE FOR PROCEDURES

PROCEDURE	IN-NETWORK	OUT-OF-NETWORK
Type I Preventive Services	100%	100%
Type II Basic Services	80%	80%
Type III Major Services	50%	50%
Type IV Ortho Services	50%	50%

SERVICES

Type I Preventive Dental Services, including:

- Oral evaluations – 2 in any calendar year
- Routine dental cleanings – 2 in any calendar year (frequency combined with periodontal maintenance)
- Fluoride treatment – 1 in any 6 month period. *Only for children under age 19*
- Sealants – no more than 1 per tooth in any 36 month period, only for permanent molar teeth. *Only for children under age 14*
- Space maintainers – *only for children under age 19*
- Bitewing x-rays – 1 in any 12 month period
- Intraoral complete series x-rays – 1 in any 60 month period
- Genetic test for susceptibility to oral diseases

Type II Basic Dental Services, including:

- New fillings
- Simple extractions, incision and drainage
- Surgical extractions of erupted teeth, impacted teeth, or exposed root
- Biopsy (including brush biopsy)
- Endodontics (includes root canal therapy) – 1 per tooth in any 24 month period
- General anesthesia/IV sedation – medically required
- Minor gum disease (non-surgical periodontics)

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- Orthodontic treatment is limited to your dependent children up to age 26

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- No waiting period for preventive, basic or major services
- 12 months for orthodontic services

Frequently asked questions (basic plan)

How does a PPO work?

PPO stands for Participating Provider Organization. With a dental PPO plan, dental providers agree to participate in a dental network by offering discounted fees on most dental procedures. When you visit a provider in the network, you could see lower out-of-pocket costs because providers in the network agree to these pre-negotiated discounted fees on eligible claims. Treatment is available from out-of-network dentists, but their fees are subject to an allowable charge and could be higher.

How do I find a dentist?

Simply visit www.sunlife.com/findadentist. Follow the prompts to find a dentist in your area who participates in the PPO network. You do not need to select a dentist in advance. The PPO network for your plan is the Sun Life Dental Network® with 145,000+ unique dentists³.

Do I have to choose a dentist in the PPO network?

No. You can visit any licensed dentist for services.

Are my dependents eligible for coverage?

Yes. Your plan offers coverage for your spouse⁴ and dependent children. An eligible child is defined as a child to age 26.⁵

What if my spouse and I work for the same employer?

Under the policy, if you are married to another employee, you should check with your benefits administrator to confirm whether you are eligible to enroll your spouse as a dependent and to confirm any additional considerations for enrolling dependent children (if dependent child coverage is available).

What if I have already started dental work, like a root canal or braces, that requires several visits?

Your coverage with us may handle these procedures differently than your prior plan. To ensure a smooth transition for work in progress, call our dental claims experts before your next visit at 800-442-7742.

Do I have to file the claim?

Many dentists will file claims for you. If a dentist will not file your claim, simply ask your dentist to complete a standard American Dental Association (ADA) claim form and mail it to Sun Life, PO Box 311, Milwaukee, WI 53201-0311.

How can I get more information about my coverage or find my dental ID card?

After the effective date of your coverage, you can view benefit information online through your Sun Life account.

To create an account go to www.sunlife.com/account and register. You can also access this information from our mobile app – Sun Life Dental (U.S.), which is available for Apple and Android devices. Or you can call Sun Life's Dental Customer Service at 800-442-7742 any time, day or night, to access our automated system.

What value added benefits does my plan include?

Your plan includes our Lifetime of Smiles® program, with benefits many people prefer, such as brush biopsies for the early detection of oral cancer.

When should I consider a pre-determination of benefits?

We recommend them for any dental treatment expected to exceed \$500. Pre-determinations allow us to review your provider's treatment plan to let you know before treatment is started how much of the work should be covered by the plan, and how much you may need to cover.

1. Provided for informational purposes only. For further details you should talk to your dental provider.

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3. Sun Life's dental networks include its affiliate, Dental Health Care Alliance, L.L.C.® (DHA), and dentists under access arrangements with other dental networks. Nationwide counts are state level totals.

4. If permitted by the Employer's employee benefit plan and not prohibited by state law, the term "spouse" in this benefit includes any individual who is either recognized as a spouse, a registered domestic partner, or a partner in a civil union, or otherwise accorded the same rights as a spouse.

5. Please see your employer for more specific information.

Read the *Important information* section for more details including limitations and exclusions

Frequently asked questions (enhanced plan)

How does a PPO work?

PPO stands for Participating Provider Organization. With a dental PPO plan, dental providers agree to participate in a dental network by offering discounted fees on most dental procedures. When you visit a provider in the network, you could see lower out-of-pocket costs because providers in the network agree to these pre-negotiated discounted fees on eligible claims. Treatment is available from out-of-network dentists, but their fees are subject to an allowable charge and could be higher.

How do I find a dentist?

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Dental plan provisions

Benefit adjustments

Benefits will be coordinated with any other dental coverage. Under the Alternative Treatment provision, benefits will be payable for the most economical services or supplies meeting broadly accepted standards of dental care.

Late entrant

If you or a dependent apply for dental coverage more than 31 days after you become eligible, you or your dependent are a late entrant. The benefits for the first 24 months for late entrants will be limited as follows:

TIME COVERED CONTINUOUSLY UNDER THE PLAN	BENEFITS PROVIDED FOR ONLY THESE SERVICES
Less than 6 months	Preventive Services
At least 6 months but less than 12 months	Preventive Services and fillings under Basic Services
At least 12 months but less than 24 months	Preventive and Basic Services
At least 24 months	Preventive, Basic, Major and Ortho Services

We will not pay for treatments subject to the late entrant limitation, and started or completed during the late entrant limitation period.