Group Dental

Plan design

Plan design summary

Dental plan overview	
Eligible Employees:	All Full-Time United States Shareholders working in the United States who are scheduled to work a minimum of 30 hours per week
	All Full-Time United States Consultants working in the United States who are scheduled to work a minimum of 30 hours per week
Effective Date:	January 1, 2024
Plan type	PPO
Dental PPO Network	Sun Life Dental NetworksM
In-Network Reimbursement	Sun Life Dental NetworksM
Out-of-Network Reimbursement	90th Percentile of the Usual and Customary Charge
Orthodontic coverage (Type IV)	This plan includes Child Only Orthodontic coverage. A person must be covered under a Dental Plan to be eligible for Orthodontic coverage
Dependent Coverage Children	Children to age 26
Annual Enrollment	Yes
Employee coverage contributions	Employee pays for a portion or all of the cost of Employee coverage
Dependent coverage contributions	Employee pays for a portion or all of the cost of Dependent coverage

The listed coinsurance percentages shown below represent the portion of Sun Life's allowable charge for which the plan will be responsible. Network providers agree to accept the network's allowable charge for covered services as payment in full. If covered employees or their eligible dependents receive services from a non-network provider, Sun Life will apply the coinsurance percentages shown below to 90th Percentile of the usual and customary charge for covered services and they will be responsible for the difference up to the provider's charge.

Calendar Year Deductible

Procedure Type	In-Network Deductible	Out-of-Network Deductible
Type I Preventive Services	Not applicable	
Type II Basic Services	$50 individual/ $150 family	$50 individual/ $150 family
Type III Major Services		
Type IV Ortho Services	Not applicable	

Deductible values are combined between In-Network and Out-of-Network.

Coinsurance

	In-Network	Out-of-Network
Type I Preventive Services	100%	100%
Type II Basic Services	90%	80%
Type III Major Services	60%	50%
Type IV Ortho Services	50%	50%

Benefit Waiting Periods

A Late Entrant Benefit Waiting Period of 6 months for Type II Basic Restorations, 12 months for all other Type II Basic Services, and 24 months for Type III Major Services will apply to employees who enroll in this dental plan more than 31 days after becoming eligible.

A Late Entrant Benefit Waiting Period of 24 months for Type IV Orthodontic Services will apply to employees who enroll in this dental plan more than 31 days after becoming eligible.

Calendar Year Maximum Benefit

	In-Network	Out-of-Network
Types I, II and III (Preventive, Basic and Major) Services	$2,000 per person	$1,500 per person
Type IV Ortho Services	$750 lifetime per child under age 26	$750 lifetime per child under age 26

Covered Expenses

Type I Preventive covered dental expenses	Coverage limitations
Oral Evaluations	1 in any 6 consecutive months
Dental Prophylaxis (Cleanings)	1 per 6 months - frequency combined with Periodontal Maintenance and is limited to 4 in any 12 month consecutive period
Fluoride Treatments	Covered Persons under age 14 1 in any 6 consecutive months
Sealants	Covered Persons under age 14 Once per tooth per 36 consecutive months on permanent first and second molars
Full Mouth X-Rays	1 in 60 consecutive months
Bite-Wing X-Rays	1 in 12 consecutive months
Type II Basic covered dental expenses	**Coverage limitations**
Palliative Treatment	Paid as a separate benefit only if no treatment, except x-rays, was rendered during the visit
Simple Extractions	No Limitation
Periodontal Maintenance	Periodontal Maintenance following active Periodontal Therapy - 1 time in 3 consecutive months. The number of Dental Prophylaxis and Periodontal Maintenance is combined and is limited to 4 in any 12 consecutive month period.
Amalgam Restorations	Once per tooth surface in any 24 consecutive months
Composite and Silicate Restorations	Once per tooth surface in any 24 consecutive months (Anterior and Posterior teeth)
Periodontics (Non-Surgical): Scaling and Root Planing	Once per 36 consecutive months per area of the mouth
Surgical Periodontics	Once per 36 consecutive months per area of the mouth
Endodontics: Root Canal Therapy	Root Canal Therapy is limited to 1 time per tooth in any consecutive 24 months period
Oral Surgery: Surgical Extraction of Erupted and Impacted Teeth	Multiple surgical services on 1 area of the mouth will be based on the most inclusive procedure
Type III Major covered dental expenses	**Coverage limitations**
Inlays and Onlays	Covered if tooth cannot be restored by fillings Once per tooth in any 10 years period
Crowns	Covered if tooth cannot be restored by filling or other means Once per tooth in any 10 years period
Crown Buildup	Once per 1O years
Full or Partial Dentures	Once in any 10 years
Fixed Bridges	Once in any 1O years
General Anesthesia	Benefits payable as a separate expense only when required for the surgical extraction of an impacted tooth
Type IV Orthodontic covered expenses	**Coverage limitations**
Orthodontic Treatment	Orthodontic treatment is limited to the Dependent Children or student age listed above