

## Limitations and Exclusions

Limitations and exclusions apply with respect to the Member's oral conditions without regard to whether or not such conditions existed before the effective date of the Member's enrollment.

### Plan Benefits are not available for:

1. Any services not specifically described in the Copayment Schedule (including but not limited to any hospital or outpatient care facility cost associated with any dental service).
2. Any part of any dental service for which a charge is incurred before the effective date of the Member's enrollment.
3. Any dental service initiated (a) before the effective date of the Member's enrollment for Plan Benefits except as provided in the ORTHODONTIC TREATMENT Article of the Evidence of Coverage or (b) after the Member's enrollment for Plan Benefits ends.
4. Services provided by Non-Plan Providers unless for Emergency Services as specifically provided in the EMERGENCY PROCEDURES Article of the Evidence of Coverage.
5. Replacement of bridgework, dentures or other fixed or removable appliances unless (a) at least five years have elapsed since such appliance was provided as a Plan Benefit, or (b) during that five-year period, appliance becomes unusable and cannot be made usable due to the Member's illness or an accident involving damage to the appliance while it is in use.
6. Replacement of dentures or other removable appliances due to (a) damage while not in use or (b) loss or theft.
7. Oral reconstruction using fixed bridgework or other fixed appliances if the overall treatment plan to achieve complete oral reconstruction involves the replacement of six or more teeth (whether those teeth are missing before treatment begins or are extracted as part of the overall treatment plan).
8. Implants or any related implant appliances, or surgery for the insertion of implants or any related implant appliances, whether fixed or removable (except as specifically provided in the dental Implant Services section of the Copayment Schedule).
9. Replacement of any tooth that has previously been replaced by an implant.

10. Replacement of a tooth by an endosteal implant after a 24 month period has elapsed since the loss of the tooth.
11. Surgical removal of implants or implant appliances, or any surgical or non-surgical services to adjust, repair, replace, or treat any problem related to an existing implant or implant appliance, whether fixed or removable.
12. Restorations or splints used to increase vertical dimension, restore occlusion, or replace or stabilize tooth structure lost by attrition.
13. Orthodontic treatment involving therapy for myofunctional problems, TMJ (temporomandibular joint) dysfunctions, micrognathia, macroglossia, cleft palate or other growth and developmental abnormalities.
14. Orthodontic treatment associated with orthognathic surgery, whether the treatment precedes or follows the surgery.
15. Extractions of third molars (wisdom teeth) that are not symptomatic, whether or not the extractions follow the completion of orthodontic treatment. Examples of symptomatic conditions include decay, odontogenic cysts, chronic pericoronitis and infection.
16. Treatment of malignancies, neoplasms or cysts, including but not limited to biopsies.

### Orthodontic Extractions

Extractions by a Plan Provider for solely orthodontic purposes are not subject to the fixed Copayments shown for extractions in the Copayment Schedule. Instead, such extractions are subject to charges reflecting a 25% reduction from that Plan Provider's normal retail charges for such extractions.

### Termination

The Member's enrollment may be terminated as stated in the TERMINATION article of the Evidence of Coverage.

This dental plan does not provide coverage for pediatric oral health services that satisfies the requirements for "minimum essential coverage" as defined by the Patient Protection and Affordable Care Act. ("PPACA").

Prepaid dental products are provided by Sun Life Assurance Company of Canada (SLOC) (Wellesley Hills, MA), under Form Series BDC-GDSA.

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STATE OF FLORIDA

# Dental Prepaid Plan – 2025

## How the plan works

You pay reduced fees called "copayments" for dental services provided by a network provider (Plan Dentist). At the time of enrollment, you must choose a Plan Dentist for each family member from the list of participating general dentists. Once you have selected a primary dentist, you will be included on your dentist's monthly member roster and you can contact the office to make your dental appointments. You will pay reduced fees called "copayments" for dental services provided by a network provider (Plan Dentist). You can change your Plan Dentist as frequently as every month with a simple call to customer service. Contact us by the 10th of the month for the change to be effective the first of the following month. You may also see a specialist without a referral from your general dentist. Please see page 2 for information on how to obtain services from a Plan Specialist.

## How do I find a Prepaid Plan Dentist?

Visit the Sun Life Financial State of Florida web site at [www.sunlife.com/STofFL](http://www.sunlife.com/STofFL) or use our mobile app – **Sun Life Dental (U.S.)**. You will be able to customize the provider search based on your input. Choose Prepaid Dental Series under Provider search.

**You must select a plan provider and notify Sun Life of your Plan Dentist selection before you can make an appointment to receive your dental care.**



## Your prepaid dental plan is simple to use when you follow these important steps:

- Verify with your Plan Dentist that you are on their roster before making a dental appointment.
- Call early for routine dental care for the best availability of appointment times.
- Be familiar with your copayment schedule to determine your costs for dental services.
- Discuss concerns regarding proposed treatments with your Plan Dentist.

No change in plan rates (again) for 2025!

### Plan prepayment fees (People First Plan Code: 4025)

Payroll Deduction	Bi-Weekly (24)	Monthly
Employee	\$7.47	\$14.93
Employee/Spouse	\$12.59	\$25.17
Employee/Child(ren)	\$16.63	\$33.26
Employee/Family	\$21.77	\$43.54

We make it simple to enroll. Visit <https://peoplefirst.myflorida.com>.

Learn more by visiting [www.sunlife.com/STofFL](http://www.sunlife.com/STofFL) or call our agent, State Securities Corp. with Enrollment questions at **800-277-2300**.



# Prepaid 225 with Ortho Copayments Plan

## Partial Copayment Schedule

### 1. Plan Dentist Services

The dental services listed in the following schedule are covered when provided by the Member's selected Plan Dentist. If Member requires dental specialty services that cannot be provided by selected Plan Dentist, Member may obtain from a Plan Specialty Dentist the services marked as dental specialty services (S) in this Section 1. No referral from Member's selected Plan Dentist is needed to receive services from a Plan Specialty Dentist. The Member will be responsible for paying the amount listed in the "Member Copayment" column (plus any applicable lab fees (\*\*)) at the time the service is received, or in accordance with the Plan Provider's billing procedures.

Dental services obtained from a Plan Specialty Dentist that are not listed and marked as dental specialty services (S) in this Section 1 below will be provided to Member at reduced charges. A 15% reduction from that Plan Specialty Dentist's normal retail charges applies to services obtained from a Plan Specialty Dentist whose practice is limited to endodontics. A 25% reduction from that Plan Specialty Dentist's normal retail charges applies to services obtained from any other Plan Specialty Dentist (including, but not limited to, a Plan Specialty Dentist whose practice is orthodontics). Member is responsible for paying the entire reduced charge either at the time the service is received or in accordance with Plan Specialty Dentist's billing procedures.

To fully understand the benefits, exclusions and limitations of this plan, the Member should consult the Evidence of Coverage. The Plan Provider is permitted to charge the member for any missed appointments if the Member fails to give at least 24 hours notice. The charge may not exceed \$25.00.

Services marked with a single asterisk (\*) below also require separate payment of laboratory charges. The laboratory charges must be paid to the Plan Provider in addition to any applicable copayment for the service.

Payment for each service of a Non-Plan Dentist (at that dentist's normal retail charge) is the responsibility of the Member, except for Plan Benefits for covered dental Emergency Services.

This is a partial copayment list. **This is not the full copayment schedule.** The full copayment schedule is available on the website at [www.sunlife.com/STofFL](http://www.sunlife.com/STofFL).

ADA Code**	Plan Dentist Treatment**	Member Copayment
<b>Appointments</b>		
0120	Periodic oral evaluation	No Charge
0140	Limited oral evaluation - problem focused	No Charge
0150	Comprehensive oral evaluation - new or established patient (once in any 6 calendar months)	No Charge
0180	Comprehensive periodontal evaluation - new or established patient	No Charge
None	Office visit - during regularly scheduled hours	10.00
9440	Office visit - after regularly scheduled hours	25.00
0210	X-ray - intraoral, complete series including bitewings (once in any 3 calendar years)	No Charge
0220	X-ray - intraoral, periapical first film	No Charge
0230	X-ray - intraoral, periapical each additional film	No Charge
0270	X-ray - extraoral, bitewing, single film	No Charge
0272	X-ray - bitewing, two films (once in any 6 calendar months)	No Charge
0274	X-ray - bitewing, four films (once in any 6 calendar months)	No Charge
0330	X-ray - panoramic film (once in any 3 calendar years)	No Charge
<b>Preventive Dentistry</b>		
1110	Routine Prophylaxis - adult (once in any 6 calendar months)	No Charge
1120	Routine Prophylaxis - child (once in any 6 calendar months)	No Charge
1206	Topical application of fluoride varnish	No Charge
1351	Application of sealant, per tooth	No Charge
<b>Restorative Dentistry (Fillings/Crowns)</b>		
2140	Amalgam - one surface, primary or permanent	10.00
2150	Amalgam - two surfaces, primary or permanent	15.00
2160	Amalgam - three surfaces, primary or permanent	20.00
2161	Amalgam - four or more surfaces, primary or permanent	25.00
2330	Resin Filling - one surface, anterior	25.00
2331	Resin Filling - two surfaces, anterior	35.00
2332	Resin Filling - three surfaces, anterior	50.00
2335	Resin Filling - four or more surfaces or involving incisal angle, anterior	75.00
2391	Resin Filling - one surface, posterior	60.00
2392	Resin Filling - two surfaces, posterior	70.00
2393	Resin Filling - three surfaces, posterior	80.00
2394	Resin Filling - four or more surfaces, posterior	95.00
2750*	Crown - Porcelain to high noble metal	225.00
2751*	Crown - Porcelain to base metal	225.00
2790*	Crown - full cast high noble metal	225.00
2791*	Crown - full cast base metal	225.00
2920	Re-cement or re-bond crown	15.00

# Prepaid Plan 225 with Ortho Copayments Plan

## Partial Copayment Schedule

### 2. Orthodontia Services

The dental services listed in the following schedule are covered when provided by a Plan Specialty Dentist. Member is responsible for paying the amount in the Member Copayment column either at the time the service is received or in accordance with Plan Specialty Dentist's billing procedures.

ADA Code**	Plan Dentist Treatment**	Member Copayment
<b>Restorative Dentistry (Fillings/Crowns)</b>		
2930	Prefabricated stainless steel crown - primary tooth	85.00
2950	Core buildup, including any pins	75.00
2954	Prefabricated post and core, in addition to crown	80.00
<b>Endodontics (Root Canals)</b>		
3310	Root Canal - Anterior (excluding final restoration)	110.00
3320	Root Canal - Premolar (excluding final restoration)(S)	225.00
3330	Root Canal - Molar (excluding final restoration)(S)	250.00
<b>Periodontics</b>		
4341	Periodontal scaling and root planing, four or more teeth per quadrant(S)	75.00
4910	Periodontal maintenance (2 per calendar yr)	45.00
<b>Removable Prosthodontics (Dentures)</b>		
5110*	Complete upper denture	305.00
5120*	Complete lower denture	305.00
5213*	Partial denture - upper (cast metal framework acrylic base)	385.00
5214*	Partial denture - lower - (cast metal framework/acrylic base)	385.00
<b>Fixed Prosthodontics or Bridges</b>		
6751*	Retainer Crown - Porcelain fused to base metal per unit	225.00
<b>Oral Surgery</b>		
7140	Extraction, erupted tooth or exposed root	18.00
7210	Surgical removal of erupted tooth removal/sectioning(S)	65.00
7230	Removal of impacted tooth - partial bony(S)	95.00
7240	Removal of impacted tooth - complete bony(S)	140.00
<b>Anesthesia, Analgesia, and Sedation</b>		
9222	Deep sedation/general anesthesia (first 15 minutes)	140.00
9223	Deep sedation/general anesthesia (each subsequent 15 minutes)	45.00

### 2. Orthodontia Services

The dental services listed in the following schedule are covered when provided by a Plan Specialty Dentist. Member is responsible for paying the amount in the Member Copayment column either at the time the service is received or in accordance with Plan Specialty Dentist's billing procedures.

ADA Code**	Plan Dentist Treatment**	Member Copayment
<b>Orthodontics</b>		
None	Bracketing (for D8070, D8080 or D8090)***	300.00
D8070	Comprehensive orthodontic treatment of the transitional dentition	2000.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition	2000.00
D8090	Comprehensive orthodontic treatment of the adult dentition	2200.00
D8660	Pre-orthodontic treatment visit	100.00
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	250.00
D8703	Replacement of lost or broken retainer - maxillary (first incident)	10.00
D8703	Replacement of lost or broken retainer - maxillary (additional incidents)	50.00
D8704	Replacement of lost or broken retainer - mandibular (first incident)	10.00
D8704	Replacement of lost or broken retainer - mandibular (additional incidents)	50.00

The Orthodontic Copayments listed above only apply during the first 24 months of active treatment and are only available once per lifetime. After 24 months of active treatment, the above Orthodontic Copayments are no longer applicable, and the listed services will be provided to Member at a 25% reduction from the Plan Specialty Dentist's normal retail charge. Member is responsible for paying the entire reduced charge either at the time the service is received or in accordance with Plan Specialty Dentist's billing procedures. This is a partial copayment schedule only. It is not an Evidence of Coverage. Please see the Group Dental Service Agreement, Evidence of Coverage, and Copayment Schedule, which determine all rights, benefits, and applicable limitations and exclusions. Listed copayments apply only to Plan Specialty Dentists who perform the corresponding listed services. Plan Specialty Dentists may not perform or offer all services listed. Availability and participation of Specialty Dentists are subject to change.

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\*\*\*Service does not have an American Dental Association Current Dental Terminology code or descriptor.