Secure Choice Dental Plan

Benefits Include Cosmetic Dentistry and Orthodontics | For use in Texas

Secure Choice Plan

The Secure Choice plan provides dental benefits with prepayment fees. To receive the benefits of the Secure Choice Plan you will need to select a Plan Dentist for you and your family members from the list of Plan Dentists. Please note that you may choose a different dentist for each family member.

Features:

- No deductibles
- No claim forms
- No annual maximum
- Fixed copayment schedule for Plan Dentists
- Reduced fees on Orthodontic procedures for children and adults
- No referral required for Specialist benefits
- Benefits are payable for pre-existing dental conditions within the copayment schedule

Prepayment Fee Options	
Annual Prepayment Fees	
Individual	$115.28
Individual + One dependent	$195.10
Family	$307.72
Or Automatic monthly bank draft	
Accounts are drafted on the 15th of each month prior to the month of benefits. A monthly administration charge is included in the fees below.	
Individual	$10.86
Individual + One dependent	$17.51
Family	$26.89
$35.00 Enrollment Fee	

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What are copayments?
Copayments are reduced fees that you pay directly to the dentist for some dental treatments. A partial list of some frequently used dental treatments is included in this brochure. This list shows you the potential savings with this Plan versus what you would pay without this Plan.

Cosmetic dentistry
We understand the importance of your appearance. That's why we have included cosmetic services, such as bleaching and bonding procedures, in your plan benefits.

Orthodontic benefits
The Secure Choice Plan includes reduced fees on Orthodontic procedures for children and adults. Plan Orthodontists provide reduced fees of 25% off his or her normal retail charge. Orthodontic services are available only in areas where this Plan has Plan Orthodontist(s) who provide those services. Orthodontic treatment begun prior to your plan effective date is not eligible for this benefit.

Specialist benefits
Should the services of a specialist (for example, oral surgeon, endodontist, orthodontist, periodontist, or pedodontist) be necessary you may seek treatment from any Plan Specialist listed in our printed or online directory. If an oral surgeon, orthodontist, periodontist or pedodontist provides treatment you will receive 25% off that specialist's normal retail charges. For treatment by an endodontist you will receive 15% off that specialist's normal retail charges. Specialist services are available only in areas where this Plan has Plan Specialist(s). Please note that payment for a service performed by a Non-Plan Specialist is your responsibility.

When will I receive a membership card?
Once your application has been processed, we will provide you with a membership card, the Individual Dental Service Agreement, and a complete list of copayments. Your effective date will be provided with your membership materials.

What if I need to change my dentist?
You may change dentists by simply calling the Customer Service Department at 800-380-6347.

How do I receive care?
After your effective date, phone the dentist you selected, and tell the office that you have coverage. They will schedule your appointment to see the dentist.

Who is eligible?
You, your spouse and dependent children as defined by state law.

When do I renew my dental plan?
If you select the annual payment method, a renewal notification and billing statement will be provided to you in advance of your anniversary date. If you select the monthly bank draft method for payment, no action is required to renew your dental plan.

Renewal/Cancellation/Termination
This Plan renews at each yearly anniversary of the effective date. Company and Subscriber each have the right to terminate the Plan with prior written notice. Please consult the Individual Dental Service Agreement for details concerning renewability, cancellation and termination.

Sample Copayments for the Secure Choice Plan

The following is a sample of some frequently used dental procedures. When you enroll for the plan, you will pay reduced fees called copayments. These reduced fees are only available from providers who participate in our network. After you enroll, a complete list of copayments will be provided to you along with your Individual Dental Service Agreement. The sample below demonstrates potential savings with the Secure Choice plan and may not reflect your actual results. Please see the copayment schedule for a complete list of services covered by the plan.

The Plan Dentist you select may not perform all procedures listed. The copayments shown apply to those Plan Dentists who perform those services. Therefore, you are encouraged to discuss availability of the scheduled services with your Plan Dentist. Charges for procedures not listed on the Copayment Schedule that are performed by your Plan Dentist are not covered under the Secure Choice plan.

Should you require dental services that your selected Plan Dentist is unable to provide, you may obtain those services from a Plan Specialist at a reduced rate. No referral is needed from your Plan Dentist in order for you to obtain services from a Plan Specialist. There is no applicable copayment schedule for Plan Specialist services. Instead, the following reductions off the Plan Specialist's normal retail charges apply to all services received from a Plan Specialist. A 15% reduction applies if the Plan Specialist is an endodontist. A 25% reduction applies if the Plan Specialist is any other type of specialist, including but not limited to an orthodontist. You are responsible for paying the entire reduced charge at the time the service is received, or in accordance with the Plan Specialist's billing procedures.

Payment for each service of a Non-Plan Dentist or Non-Plan Specialist (at that provider's normal retail charge) is your responsibility, except for limited Plan Benefits for covered dental Emergency Services for temporary pain relief.

Availability and participation of Plan Dentists and Plan Specialists are subject to change.

continued

Dental treatment	Your cost with Secure Choice Plan	Your cost Average Retail Charges[1]
Appointments		
Periodic Oral Evaluation	**No charge**	**$53**
Limited Oral Exam	**$25**	**$79**
Diagnostic Dentistry		
Complete X-Ray Series, Including Bitewings	**$5**	**$141**
Preventive Dentistry		
Routine Cleaning - Adult/Child^	**$5/$5**	**$94/$72**
Restorations		
Silver Fillings - 2 Surfaces	**$20**	**$181**
White Fillings - 2 Surfaces (posterior)	**$90**	**$232**
Crowns - Porcelain to High Noble Metal (cost of precious & semi-precious metal is additional)	**$300****	**$1,134**
Endodontics and Periodontics		
Root Canal - Molar	**$200**	**$1,195**
Scaling and Root Planing (per quadrant)	**$55**	**$259**
Dentures		
Partial Upper	**$390****	**$1,177**
Partial Lower	**$390****	**$1,189**
Oral Surgery		
Single Tooth Extraction	**$20**	**$174**
Removal of Impacted Tooth (partial bony)	**$100**	**$445**
Orthodontics		
Orthodontic treatment for children and adults is provided at a 25% reduction from the Plan Specialist's normal retail charges.		

^Once every six months.

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

1.The Average Retail Charges were determined by "Company" claims analysis for the year 2021 for the state of Texas. The Retail Charges represent a mean average rounded to the nearest dollar representing what you may pay without the plan services.

For further information contact: 800-380-6347

Sun Life
Attn: Individual Dental Team
P.O. Box 419596
Kansas City, MO 64141-6596

www.slfdental.com

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How do I join?

Three easy steps to enrolling in the Secure Choice Plan:

1. **Select** a general dentist from the Plan Dentist Directory or online at www.slfdental.com. Each family member may choose a different Plan Dentist..

2. **Complete** the attached application form. Be sure to include the Dental Facility Number of each dentist you have selected in the space provided and detach the application form from the brochure.

3. **Choose** your payment option. If you choose the **annual prepayment fee method** include the appropriate prepayment fee, the $35 enrollment fee, and the completed application form and mail them to us. The annual prepayment fee may be paid by credit card for your convenience.

   If you choose the **automatic monthly bank draft** method complete the Authorization Agreement on the reverse side of the application form, include a voided check, the first month's prepayment fee, the $35 enrollment fee and mail them to us. Monthly prepayment fees will thereafter be drawn automatically from your bank account. While we accept automatic bank drafts from checking or savings accounts, **we cannot accept personal checks on a monthly basis.**

Patient Protection and Affordable Care Act

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").

Limitations and Exclusions

No benefits will be payable for the following:

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 member's enrollment.

3. Any dental service initiated after Member's enrollment ends.

4. Services provided by Non-Plan Providers unless for Emergency Services as specifically provided in the EMERGENCY SERVICES Article of the Individual Dental Service Agreement.

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 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.

9. 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.

10. Restorations or splints used to increase vertical dimension, restore occlusion, or replace or stabilize tooth structure lost by attrition.

11. Orthodontic treatment involving therapy for myofunctional problems, TMJ (temporomandibular joint) dysfunctions, micrognathia, macroglossia, cleft palate or other growth and developmental abnormalities.

12. Orthodontic treatment associated with orthognathic surgery, whether the treatment precedes or follows the surgery.

13. 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.

14. Treatment of malignancies, neoplasms or cysts, including but not limited to biopsies.

Renewable at option of Company.

Application Form

Please retain a copy of this application for your records

Your Social Security Number	Last name	First name	Middle initial	Sex M ☐ F ☐

Agent number:

IMPORTANT

Write the Dental facility Number of the dentist(s) you choose from the directory in this space(s) below.

Your date of birth / /	Address

Home Phone ( )	City	State	Zip Code+4	Email address

Do you have a disability that affects your ability to communicate or read? Yes ☐ No ☐ If yes, please provide details: _____

Written/spoken language preference ☐ English ☐ Spanish ☐ other _____

LIst dependents to be enrolled First name / Middle initial / Last name (if different)	Relationship	Date of birth	Sex
Spouse		/ /	M ☐ F ☐
Child		/ /	M ☐ F ☐
Child		/ /	M ☐ F ☐

Prepayment Fee amount

$_____

Enrollment Fee $ 35.00

Total enclosed $_____

Select payment choice:

☐ **Annual Payment:** make the check payable to Sun Life Assurance Company of Canada

☐ **Charge my annual prepayment fees**

☐ **Automatic Monthly Bank Draft:** complete the Authorization Agreement on the reverse side of this form.

☐ Visa ☐ MasterCard ☐ Discover Exp. Date _____ CVV: _____

By my signature below, I understand that this Dental HMO Plan is a non-refundable one (1) year program. I also understand that a full description of the plan will be provided in the Individual Dental Service Agreement and that the dentist I select may or may not perform all of the procedures listed on the Copayment Schedule. I authorize the dentist who has rendered procedures to me or members of my family to make available to United Dental Care of Texas, Inc., Sun Life Assurance Company of Canada and its affiliated dental companies my dental records, photocopies or information regarding such procedures to the extent permitted by law. This authorization is not governed by HIPAA; however, when necessary, I may be asked to execute a HIPAA authorization form, allowing United Dental Care of Texas, Inc., Sun Life Assurance Company of Canada and its affiliated dental companies to use and disclose protected health information.

Agent's Signature _____ Date _____

Subscriber's Signature _____ Date _____

Authorization Agreement For Automatic Monthly Bank Draft

IMPORTANT: If you selected the Monthly Bank Draft Payment method, enclose a voided check and your first month's prepayment fee with this form and send them to us.

Name(s)	Social Security Number									Checking ☐ Savings ☐

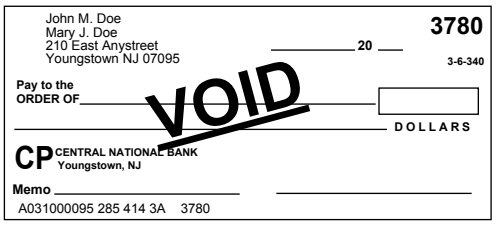
I (we) hereby authorize Sun Life Assurance Company of Canada to initiate debit entries, and to initiate if necessary, credit entries and adjustments for any debit entry corrections to my (our) account indicated below and the Financial Institution named below to debit and/or credit same to such account.

Bank name	City	State

Include your Checking or Savings Account Number in the boxes below:

Routing number																
Account number																

Prepayment fees are deducted from your authorized account on the 15th of the month prior to the month of benefits. The Authorization Agreement automatically renews if the Individual Dental Service Agreement renews.



This authorization is to remain in full force and effective until Sun Life Assurance Company of Canada has received WRITTEN notification from me (or either of us) of its termination by the 10th of the month prior to the month when the enrollment is to be terminated.

Signature _____ Date _____