Secure Choice Dental Plan

Benefits Include Cosmetic Dentistry and Orthodontics | For use in New York

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 and Plan Specialists
- Copayments for 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	$232.32
Individual + One dependent	$371.64
Family	$569.52
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	$19.36
Individual + One dependent	$30.97
Family	$47.46
$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 copayments for Orthodontic procedures for children and adults. 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 be necessary you may seek treatment from any Plan Specialist listed in our printed or online directory. Please see the Individual Dental Service Agreement and Copayment Schedule of Benefits for a complete listing of covered Plan Specialist services. 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.

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").

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 (IDSA). The sample below demonstrates potential savings with the Secure Choice plan and may not reflect your actual results. Please see the Copayment Schedule of Benefits 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 of Benefits 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. No referral is needed from your Plan Dentist in order for you to obtain services from a Plan Specialist. Please see the IDSA and Copayment Schedule of Benefits for a complete list of covered Plan Specialist services.

Payment for each service of a Non-Plan Dentist or Non-Plan Specialist (at that provider's normal retail charge) is your responsibility, except as stated in the IDSA and Copayment Schedule of Benefits.

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

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Dental treatment	Your cost with Secure Choice Plan	Your cost with Average Retail Charges[1]
Appointments		
Periodic Oral Evaluation	**No charge**	**$65**
Limited Oral Exam	**$25**	**$91**
Diagnostic Dentistry		
Complete X-Ray Series, Including Bitewings	**No charge**	**$162**
Preventive Dentistry		
Routine Cleaning - Adult/Child^	**$5/$5**	**$115/$86**
Restorations		
Silver Fillings - 2 Surfaces	**$25**	**$186**
White Fillings - 2 Surfaces (posterior)	**$50**	**$249**
Crowns - Porcelain to High Noble Metal (cost of precious & semi-precious metal is additional)	**$310****	**$1,295**
Endodontics and Periodontics		
Root Canal - Molar	**$500**	**$1,348**
Scaling and Root Planing (per quadrant)	**$75**	**$266**
Dentures		
Partial Upper	**$320****	**$1,298**
Partial Lower	**$320****	**$1,382**
Oral Surgery		
Single Tooth Extraction	**$30**	**$255**
Removal of Impacted Tooth (partial bony)	**$90**	**$522**
Orthodontics		
See the Copayment Schedule of Benefits for a complete listing of covered orthodontic procedures		

^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 New York. 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/newyork. 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.**

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 dental service initiated (a) before the effective date of Member's enrollment or (b) after Member's enrollment ends.
3. Services provided by Non-Plan Providers unless for Emergency Services for temporary pain relief (with limited benefits) as specifically provided in the EMERGENCY SERVICES Article of the Individual Dental Service Agreement.
4. Treatment of malignancies, neoplasms or cysts, including but not limited to biopsies.

Sun Life and Health Insurance Company (U.S.) 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:**
Your date of birth / /	Address				**IMPORTANT** Write the Dental facility Number of the dentist(s) you choose from the directory in this space(s) below.
Home phone ( )	City	State	Zip Code+4	Email Address	

List dependents to be enrolled First name	Middle initial	Last name (if different)	Relationship	Date of birth	Sex	**Dental Facility Number**
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 and Health Insurance Company (U.S.)

☐ **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 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 Sun Life and Health Insurance Company (U.S.) 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 Sun Life and Health Insurance Company (U.S.) and its affiliated dental companies to use and disclose protected health information.

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Agent's Signature _____ Date _____

Subscriber's Signature _____ Date _____

This is an important document that will become part of your contract. Benefits administered and provided by Sun Life and Health Insurance Company (U.S.).

Authorization Agreement For Automatic Monthly Bank Draft

IMPORTANT: If you selected the Monthly Bank Draft Payment method, enclose a voided check, your first month's prepayment fee and $35 enrollment fee with this form and send them to us.

Name(s)	Social Security Number										Checking ☐ Savings ☐

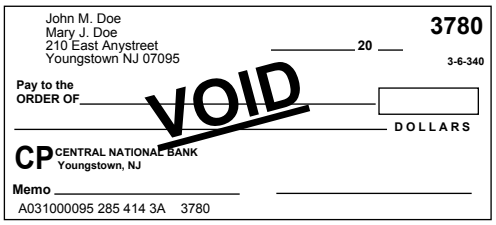
I (we) hereby authorize Sun Life and Health Insurance Company (U.S.) to initiate debit entries, and to initiate if necessary, credit entries and adjustments for any debit entry corrections to my (our) account indicated below and the Financial Institution named below to debit and/or credit same to such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