Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: UDC Dental California, Inc.
Type of Product Line: Individual Prepaid
Effective Date: **As shown on your Enrollment Confirmation**

Name of Product: Secure Choice Dental
Plan Phone #: 800-380-6347
Plan Website: www.slfdental.com

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND WHAT YOU WILL PAY FOR COVERED SERVICES. THIS IS A SUMMARY ONLY AND DOES NOT INCLUDE THE PREMIUM COSTS OF THIS DENTAL BENEFITS PACKAGE. PLEASE CONSULT YOUR EVIDENCE OF COVERAGE AND DENTAL CONTRACT FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. FOR MORE INFORMATION ABOUT YOUR COVERAGE, VISIT THE PLAN WEBSITE AT www.sunlife.com/account OR CALL 800-380-6347.

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	In-Network	Out-of-Network
Dental	No Deductible	Not Applicable

- **There is no deductible.**
- A **deductible** is the amount you are required to pay for covered dental services each plan year before the plan begins to pay for the cost of covered dental treatment.
- **In-network services** are dental care services provided by dentists or other licensed dental care providers that contract with your plan to provide dental services.
- **Out-of-network services** are dental care services provided by dentists or other licensed dental care providers that are not contracted with your plan.

Part III: MAXIMUMS PLAN WILL PAY

Maximums	In-Network	Out-of-Network
Annual Maximum	$0	Not Applicable
Lifetime Maximum for Orthodontia	$0	Not Applicable

- **Annual maximum** is the maximum dollar amount your plan will pay toward the cost of dental care within a specific period of time, usually a consecutive 12-month or calendar year period.
- **Lifetime maximum** means the maximum dollar amount your plan providing dental benefits will pay for the life of the enrollee. Lifetime maximums usually apply to specific services, such as orthodontic treatment.

Part IV: WAITING PERIODS

Waiting Periods: A waiting period is the amount of time that must pass before you are eligible to receive benefits for all or certain dental treatments. **There is no waiting period.**

Part V: WHAT YOU WILL PAY

All copayments and coinsurance costs shown in this chart apply after your deductible has been met, if a deductible applies. The Common Dental Procedures fit into one of the following applicable categories: Preventive & Diagnostic, Basic or Major. The Benefit Limitations and Exclusions column includes common limitations and exclusions only. For a full list, see the full disclosure document referenced in the Benefit Limitations and Exclusions column.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions For a full listing, refer to the Evidence of Coverage, Article: "Limitations and Exclusions" and the Copayment Schedule or to our Plan Website
Oral Exam - comprehensive	Preventive & Diagnostic	$0	100%	

Common Dental Procedures	**Category**	**In-Network**	**Out-of-Network**	**Benefit Limitations and Exclusions** **For a full listing, refer to the Evidence of Coverage, Article: "Limitations and Exclusions" and the Copayment Schedule or to our Plan Website**
Bitewing X-ray – single	Preventive & Diagnostic	$0	100%	Plan Specialist is excluded
Cleaning – adult prophylaxis	Preventive & Diagnostic	$10	100%	Once in every 6 months
Filling – resin-based composite, one surface, anterior	Basic	$40	100%	
Extraction, Erupted Tooth or Exposed Root – simple	Basic	$20	100%	Plan Specialist is excluded
Root Canal – molar (excluding final restoration)	Basic	$325	100%	
Scaling and Root Planing – 4 or more teeth per quadrant	Basic	$90	100%	
Ceramic Crown	Major	$280	100%	Plan Specialist is excluded
Removable Partial Denture – maxillary-cast metal framework	Major	$495	100%	Plan Specialist is excluded
Extraction, Erupted Tooth with Bone Removal - surgical	Basic/Major	$70	100%	

Common Dental Procedures	**Category**	**In-Network**	**Out-of-Network**	**Benefit Limitations and Exclusions** **For a full listing, refer to the Evidence of Coverage, Article: "Limitations and Exclusions" and the Copayment Schedule or to our Plan Website**
Orthodontia – comprehensive treatment of adolescent	Orthodontia	$1695	100%	

Part VI: COVERAGE EXAMPLES

THESE EXAMPLES DO NOT REPRESENT A COST ESTIMATOR OR GUARANTEE OF PAYMENT. The examples provided represent commonly used services in the categories of Diagnostic and Preventive, Basic and Major Services for illustrative purposes and to compare this product to other dental products you may be considering. Your actual costs will likely be different from those shown in the chart below depending on the actual care you receive, the prices your providers charge and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and the summary of excluded services under the plan.

Dana Has a Dental Appointment with a New Dentist	**Sam Needs a Tooth Filled**	**Maria Needs a Crown**
New patient exam, x-rays (FMX) and cleaning	Resin-based composite – one surface, posterior	Crown – porcelain/ceramic substrate

Dana's Visit	**Dana's Cost**	**Sam's Visit**	**Sam's Cost**	**Maria's Visit**	**Maria's Cost**
Total Cost of Care	In-network: $400 Out-of-network: $550	Total Cost of Care	In-network: $150 Out-of-network: $200	Total Cost of Care	In-network: $1,300 Out-of-network: $1,750
Deductible	In-network: $0 Out-of-network: Not Applicable	Deductible	In-network: $0 Out-of-network: Not Applicable	Deductible	In-network: $0 Out-of-network: Not Applicable
Annual Maximum (Plan Will Pay)	In-network: $0 Out-of-network: Not applicable	Annual Maximum (Plan Will Pay)	In-network: $0 Out-of-network: Not applicable	Annual Maximum (Plan Will Pay)	In-network: $0 Out-of-network: Not applicable
Patient Cost (copayment or coinsurance)	In-network: $20 Out-of-network: $550	Patient Cost (copayment or coinsurance)	In-network: $75 Out-of-network: $200	Patient Cost (copayment or coinsurance)	In-network: $280 Out-of-network: $1,750
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	**In-network:** $20 **Out-of-network:** $550	**In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** $75 **Out-of-network:** $200	**In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** $280 **Out-of-network:** $1,750

Dana's Visit	**Dana's Cost**	**Sam's Visit**	**Sam's Cost**	**Maria's Visit**	**Maria's Cost**
Summary of what is not covered or subject to a limitation:	Cleaning – once in every 6 months	Summary of what is not covered or subject to a limitation:	Plan Specialist is excluded	Summary of what is not covered or subject to a limitation:	Plan Specialist is excluded