## Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

## Part I: GENERAL INFORMATION

**Insurer Name: Colonial Life & Accident Insurance Company Plan Name: IDN8000 – Plan 2 with Orthodontia**
**Policy Type: PPO**                                    **Insurer Phone #: 1-888-400-9304**
**Effective Date: 01/28/2023**                             **Insurer Website: ColonialLifeDental.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 INSURER WEBSITE AT COLONIALLIFEDENTAL.COM OR CALL 1-888-400-9304.**

**THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.**

## Part II: DEDUCTIBLES

| Deductible | All Providers |
|---|---|
| Dental | $50 Individual deductible<br>Maximum 3 per family |

- **The deductible applies to all services except Class A and D Services.**
- A **deductible** is the amount you are required to pay for covered dental services each policy year before the insurer 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 insurer for alternative rates of payment for dental services.
- **Out-of-network services** are dental care services provided by dentists or other licensed dental care providers that have not contracted with your insurer for alternative rates of payment.

## Part III: MAXIMUMS POLICY WILL PAY

| Maximums | All Providers |
|---|---|
| Annual Maximum | $1,000 |
| Lifetime Maximum for Orthodontia | $1,000 per covered dependent child up to age 19 |

- **Annual maximum** is the maximum dollar amount your policy will pay toward the cost of dental care within a specific period of time, usually a consecutive 12-month or calendar year period. Not all services accrue to the annual maximum.
- **Lifetime maximum** means the maximum dollar amount your policy 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 may be a 12-month waiting period for Major (Class C) and Orthodontia (Class D). See your policy for details.**

## 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 | All Providers[1] | Benefit Limitations and Exclusions |
|---|---|---|---|
| *Oral Exam* | Preventive & Diagnostic (Class A) | 0%, deductible does not apply | Limited to 2 oral evaluation procedures, in any combination (D0120, D0145, D0150) per 12-month period. See your Policy, Schedule of Covered Dental Procedures, Page 17. |
| *Bitewing X-ray* | Preventive & Diagnostic (Class A) | 0%, deductible does not apply | Maximum of 4 films per 12-months. See your Policy, Schedule of Covered Dental procedures, Page 17. |
| *Cleaning* | Preventive & Diagnostic (Class A) | 0%, deductible does not apply | Maximum of 2 procedures per 12months. See your Policy, Schedule of Covered Dental Procedures, Page 17. |
| *Filling* | Basic (Class B) | 20% | Replacement of existing only if in place for 12-months (insured under age 19); replace existing only if in place for 36 months |

| Common Dental Procedures | Category | All Providers[1] | Benefit Limitations and Exclusions |
|---|---|---|---|
| | | | (insured over age 19). See your Policy, Schedule of Covered Dental Procedures, Page 17. |
| *Extraction, Erupted Tooth or Exposed Root* | Basic (Class B) | 20% | Maximum 1 time per tooth or site. See your Policy, Schedule of Covered Dental Procedures, Page 18. |
| *Root Canal* | Major (Class C) | 50% | 12-month waiting period. Maximum 1 time per tooth or site. See your Policy, Schedule of Covered Dental Procedures, Page 19. |
| *Scaling and Root Planing* | Major (Class C) | 50% | 12-month waiting period. Maximum of 1 each quadrant per 24 months. See your Policy, Schedule of Covered Dental Procedures, Page 19. |
| *Ceramic Crown* | Major (Class C) | 50% | 12-month waiting period. Maximum of 1 per 5 year period per tooth. Benefits may be based on the benefit for the corresponding non-cosmetic restoration. See your Policy, Schedule of Covered Dental Procedures, Page 18. |
| *Removable Partial Denture* | Major (Class C) | 50% | 12-month waiting period. Maximum of 1 per 5 year period per tooth. See your Policy, Schedule of Covered Dental Procedures, Page 20. |
| *Extraction, Erupted Tooth with Bone Removal* | Major (Class C) | 50% | 12-month waiting period. Maximum 1 time per tooth or site. Subject to review; only covered for non-elective procedures See your Policy, Schedule of Covered Dental Procedures, Page 21. |
| *Orthodontia* | Orthodontia (Class D) | 50% | 12-month waiting period. See your Policy, Schedule of Covered Dental Procedures for a full, Page 22. |

## 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[2] | |

| 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[3] | All Providers: $50 | Deductible | All Providers: $50 | Deductible | All Providers: $50 |
| Annual Maximum (Plan Will Pay) | All Providers: $1,000 | Annual Maximum (Plan Will Pay) | All Providers: $1,000 | Annual Maximum (Plan Will Pay) | All Providers: $1,000 |
| Patient Cost (copayment or coinsurance) | All Providers: 0% for exam and cleaning; 20% for x-rays | Patient Cost (copayment or coinsurance) | All Providers: 20% | Patient Cost (copayment or coinsurance) | All Providers: 50% |

| Dana's Visit | Dana's Cost | Sam's Visit | Sam's Cost | Maria's Visit | Maria's Cost |
|---|---|---|---|---|---|
| **In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):** | **In-network:** $58.73<br><br>**Out-of-network:** $394.34 | **In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):** | **In-network:** $58.96<br><br>**Out-of-network:** $164.18 | **In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):** | **In-network:** $457.15<br><br>**Out-of-network:** $1342.85 |
| Summary of what is not covered or subject to a limitation: | Exam and cleanings are 2 per 12 months. FMX Maximum of 1 per 5 years. | Summary of what is not covered or subject to a limitation: | Benefit is based on non-cosmetic restoration. Replacement of existing only if in place for 12 months if under age 19 or 36 months if over age 19. | Summary of what is not covered or subject to a limitation: | 12-month waiting period. Maximum of 1 per 5 year period per tooth. |

1 the % is the member's coinsurance they are responsible for paying.

2 Assumes crown for anterior tooth.

3 Deductible applicable for full-mouth x-ray as it is a Basic (Class B) service.