



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

### **Part I: GENERAL INFORMATION**

**Plan Name:** Starmount Managed Dental of California, Inc. dba Unum Dental HMO Plan  
**Type of Product Line:** DHMO  
**Effective Date:** Beginning on or after 01/01/23

**Name of Product:** CADHMO3  
**Plan Phone #:** 1-800-937-3400  
**Plan Website:** [www.unumdentalhmo.com](http://www.unumdentalhmo.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 [www.unumdentalhmo.com](http://www.unumdentalhmo.com) OR CALL 1-800-937-3400.

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

### **Part II: DEDUCTIBLES**

| Deductible  | In-Network | Out-of-Network |
|-------------|------------|----------------|
| Dental      | None       | None           |
| Orthodontia | None       | None           |

- **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**

| <b>Maximums</b>                            | <b>In-Network</b>                               | <b>Out-of-Network</b> |
|--------------------------------------------|-------------------------------------------------|-----------------------|
| Annual Maximum                             | No                                              | Not applicable        |
| Lifetime or Annual Maximum for Orthodontia | Lifetime: (1) course of treatment in a lifetime | 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. **Not all services accrue to the annual maximum.**
- **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 or services for all or certain dental treatments. **Your dental benefit package has 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.**

| <b>Common Dental Procedures</b> | <b>Category</b>         | <b>In-Network</b> | <b>Out-of-Network</b> | <b>Benefit Limitations and Exclusions</b>                                         |
|---------------------------------|-------------------------|-------------------|-----------------------|-----------------------------------------------------------------------------------|
| <i>Oral Exam</i>                | Preventive & Diagnostic | \$0               | Not Covered           |                                                                                   |
| <i>Bitewing X-ray</i>           | Preventive & Diagnostic | \$0               | Not Covered           | Limit of two (2) sets in any twelve month period unless diagnostically necessary. |
| <i>Cleaning</i>                 | Preventive & Diagnostic | \$0               | Not Covered           | Limit of one (1) cleaning every six (6) consecutive months.                       |

| <b>Common Dental Procedures</b>                    | <b>Category</b> | <b>In-Network</b> | <b>Out-of-Network</b> | <b>Benefit Limitations and Exclusions</b>                                                                                                                                                                                                                                                                                                                                                                                |
|----------------------------------------------------|-----------------|-------------------|-----------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <i>Filling</i>                                     | Basic           | \$15              | Not Covered           |                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <i>Extraction, Erupted Tooth or Exposed Root</i>   | Basic           | \$40              | Not Covered           | The full limitations and exclusions for this product can be found on the Combined Evidence of Coverage and Disclosure Form.                                                                                                                                                                                                                                                                                              |
| <i>Root Canal</i>                                  | Major           | \$250             | Not Covered           | The full limitations and exclusions for this product can be found on the Combined Evidence of Coverage and Disclosure Form.                                                                                                                                                                                                                                                                                              |
| <i>Scaling and Root Planing</i>                    | Basic           | \$85              | Not Covered           | Limited to four (4) quadrants per twenty-four (24) consecutive months in combination with routine prophylaxis.                                                                                                                                                                                                                                                                                                           |
| <i>Ceramic Crown</i>                               | Major           | \$350             | Not Covered           | Service will be covered only if performed by a general dentist. The full limitations and exclusions for this product can be found on the Combined Evidence of Coverage and Disclosure Form.                                                                                                                                                                                                                              |
| <i>Removable Partial Denture</i>                   | Major           | \$525             | Not Covered           | Partial dentures are not to exceed one per arch in a five (5) year period unless necessary due to natural tooth loss where the addition to an existing partial or denture is not feasible. Replacement of partial or full dentures are covered once per arch every five (5) years, except when they cannot be made functional through reline or repairs. Service will be covered only if performed by a general dentist. |
| <i>Extraction, Erupted Tooth with Bone Removal</i> | Major           | \$35              | Not Covered           | Service will be covered only if performed by a specialist. The full limitations and exclusions for this product can be found on the Combined Evidence of Coverage and Disclosure Form.                                                                                                                                                                                                                                   |
| <i>Orthodontia</i>                                 | Orthodontia     | \$1,650           | Not Covered           | Limited to one (1) course of treatment in a lifetime. The full limitations and exclusions for this product can be found on the Combined Evidence of Coverage and Disclosure Form.                                                                                                                                                                                                                                        |

### 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.

| <b>Dana Has a Dental Appointment with a New Dentist</b>  | <b>Sam Needs a Tooth Filled</b>                | <b>Maria Needs a Crown</b>          |
|----------------------------------------------------------|------------------------------------------------|-------------------------------------|
| New patient exam, x-rays (full-mouth x-ray) and cleaning | Resin-based composite – one surface, posterior | Crown – porcelain/ceramic substrate |

| <b>Dana's Visit</b>            | <b>Dana's Cost</b>                                       | <b>Sam's Visit</b>             | <b>Sam's Cost</b>                                        | <b>Maria's Visit</b>           | <b>Maria's Cost</b>                                          |
|--------------------------------|----------------------------------------------------------|--------------------------------|----------------------------------------------------------|--------------------------------|--------------------------------------------------------------|
| Total Cost of Care             | In-network: <b>\$400</b><br>Out-of-network: <b>\$550</b> | Total Cost of Care             | In-network: <b>\$150</b><br>Out-of-network: <b>\$200</b> | Total Cost of Care             | In-network: <b>\$1,300</b><br>Out-of-network: <b>\$1,750</b> |
| Deductible                     | In-network: None<br><br>Out-of-network: Not Covered      | Deductible                     | In-network: None<br><br>Out-of-network: Not Covered      | Deductible                     | In-network: None<br><br>Out-of-network: Not Covered          |
| Annual Maximum (Plan Will Pay) | In-network: None<br><br>Out-of-network: Not Covered      | Annual Maximum (Plan Will Pay) | In-network: None<br><br>Out-of-network: Not Covered      | Annual Maximum (Plan Will Pay) | In-network: None<br><br>Out-of-network: Not Covered          |

| Dana's Visit                                                                                        | Dana's Cost                                                                                                                                                | Sam's Visit                                                                                        | Sam's Cost                                             | Maria's Visit                                                                                        | Maria's Cost                                                                                                                                                                                |
|-----------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--------------------------------------------------------|------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                     |                                                                                                                                                            |                                                                                                    |                                                        |                                                                                                      |                                                                                                                                                                                             |
| Patient Cost<br>(copayment or coinsurance)                                                          | In-network: \$0<br><br>Out-of-network: \$550                                                                                                               | Patient Cost<br>(copayment or coinsurance)                                                         | In-network: \$50<br><br>Out-of-network: \$200          | Patient Cost<br>(copayment or coinsurance)                                                           | In-network: \$350<br><br>Out-of-network: \$1750                                                                                                                                             |
| <b>In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):</b> | <b>In-network: \$0<br/><br/>Out-of-network: \$550</b>                                                                                                      | <b>In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):</b> | <b>In-network: \$50<br/><br/>Out-of-network: \$200</b> | <b>In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):</b> | <b>In-network: \$350<br/><br/>Out-of-network: \$1,750</b>                                                                                                                                   |
| Summary of what is not covered or subject to a limitation:                                          | Limit of one (1) cleaning every six (6) consecutive months. X-Rays (FMX) are limited to one (1) set every three (3) years unless diagnostically necessary. | Summary of what is not covered or subject to a limitation:                                         |                                                        | Summary of what is not covered or subject to a limitation:                                           | Service will be covered only if performed by a general dentist. The full limitations and exclusions for this product can be found on the Combined Evidence of Coverage and Disclosure Form. |