Dental HMO Plan

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: CADHMO5
Plan Phone #: 1-800-937-3400
Plan Website: 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 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

Maximums	In-Network	Out-of-Network
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.

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

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Filling	Basic	$5	Not Covered	
Extraction, Erupted Tooth or Exposed Root	Basic	$30	Not Covered	The full limitations and exclusions for this product can be found on the Combined Evidence of Coverage and Disclosure Form.
Root Canal	Major	$225	Not Covered	The full limitations and exclusions for this product can be found on the Combined Evidence of Coverage and Disclosure Form.
Scaling and Root Planing	Basic	$75	Not Covered	Limited to four (4) quadrants per twenty-four (24) consecutive months in combination with routine prophylaxis.
Ceramic Crown	Major	$250	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.
Removable Partial Denture	Major	$375	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.
Extraction, Erupted Tooth with Bone Removal	Major	$25	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.
Orthodontia	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.

Dana Has a Dental Appointment with a New Dentist	**Sam Needs a Tooth Filled**	**Maria Needs a Crown**
New patient exam, x-rays (full-mouth x-ray) 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: None Out-of-network: Not Covered	Deductible	In-network: None Out-of-network: Not Covered	Deductible	In-network: None Out-of-network: Not Covered
Annual Maximum (Plan Will Pay)	In-network: None Out-of-network: Not Covered	Annual Maximum (Plan Will Pay)	In-network: None Out-of-network: Not Covered	Annual Maximum (Plan Will Pay)	In-network: None 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 (copayment or coinsurance)	In-network: $0 Out-of-network: $550	Patient Cost (copayment or coinsurance)	In-network: $45 Out-of-network: $200	Patient Cost (copayment or coinsurance)	In-network: $250 Out-of-network: $1750
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	**In-network:** $0 **Out-of-network:** $550	**In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** $45 **Out-of-network:** $200	**In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** $250 **Out-of-network:** $1,750
Summary of what is not covered or subject to a limitation:	Limit of one (1) cleaning every six (6) consectutive 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.