

Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: U40

Class: 0003

Type of Product Line: DHMO

Effective Date: Beginning on or after 12/01/2021

Name of Product: Managed Dental Care

Plan Phone #: 800-273-3330

Plan Website: manageddentalcare.net

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 MANAGEDDENTALCARE.NET OR CALL 800-273-3330.

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

<u>Deductible</u>	<u>In-Network</u>	<u>Out-of-Network</u>
Dental	None	Not Applicable
Orthodontia	None	Not Applicable

- ☐ **There is no deductible, however an office visit co-pay may apply.**
- ☐ 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

<u>Maximums</u>	<u>In-Network</u>	<u>Out-of-Network</u>
Annual Maximum	None	Not applicable
Lifetime Maximum for Orthodontia	None	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. **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.

<u>Common Dental Procedures</u>	<u>Category</u>	<u>In-Network</u>	<u>Out-of-Network</u>	<u>Benefit Limitations and Exclusions</u>
<i>Oral Exam</i>	Preventive & Diagnostic	\$0	100%	
<i>Bitewing X-ray</i>	Preventive & Diagnostic	\$0	100%	
<i>Cleaning</i>	Preventive & Diagnostic	\$0	100%	Limited to 2 in 12 months. Please consult Your Certificate of Coverage for a Detailed Description of Coverage Benefits and Limitations.

<u>Common Dental Procedures</u>	<u>Category</u>	<u>In-Network</u>	<u>Out-of-Network</u>	<u>Benefit Limitations and Exclusions</u>
<i>Filling</i>	Basic	\$20	100%	Limited to permanent teeth, up to age 16, once per tooth in 36 months. Please consult Your Certificate of Coverage for a Detailed Description of Coverage Benefits and Limitations.
<i>Extraction, Erupted Tooth or Exposed Root</i>	Basic	\$10	100%	
<i>Root Canal</i>	Major	\$170	100%	
<i>Scaling and Root Planing</i>	Basic	\$30	100%	
<i>Ceramic Crown</i>	Major	\$270	100%	Covered when recommended by the PCD. Please consult Your Certificate of Coverage for a Detailed Description of Coverage Benefits and Limitations.
<i>Removable Partial Denture</i>	Major	\$355	100%	Covered when recommended by the PCD and only if the existing denture cannot be made satisfactory by reline, rebase or repair. Please consult Your Certificate of Coverage for a Detailed Description of Coverage Benefits and Limitations.
<i>Extraction, Erupted Tooth with Bone Removal</i>	Major	\$30	100%	
<i>Orthodontia</i>	Orthodontia	\$1,500 (child) \$2,800 (adult)	100%	Child orthodontics is limited to dependent children under age 19. Please consult Your Certificate of Coverage for a Detailed Description of Coverage Benefits and Limitations.