WD PLAN
GROUP AND INDIVIDUAL

Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: Western Dental Plan
Type of Product Line: DHMO
Effective Date: 1/1/2024

Name of Product: 8000C3
Plan Phone #: 1-800-992-3366
Plan Website: https://www.westerndental.com/en-us/western-dental-group-insurance/for-members

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 HTTPS://WWW.WESTERNDENTAL.COM/EN-US/WESTERN-DENTAL-GROUP-INSURANCE/FOR-MEMBERS OR CALL 1-800-992-3366.

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	Not Applicable	Not Applicable
Lifetime or Annual Maximum for Orthodontia	Not Applicable	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	Diagnostic	$0 Copay	Not Applicable	No limitations or exclusions.
Bitewing X-ray	Diagnostic	$0 Copay	Not Applicable	1 series of 4 in any 6-month period
Cleaning	Preventative	$0 Copay	Not Applicable	3 cleanings in a 12-month period

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Filling	Minor Restorative	$0 Copay	Not Applicable	No limitations or exclusions.
Extraction, Erupted Tooth or Exposed Root	Oral Surgery	$0 Copay	Not Applicable	Extractions solely for ortho purposes.
Root Canal	Endodontics	$0 Copay	Not Applicable	No limitations or exclusions
Scaling and Root Planing	Periodontics	$0 Copay	Not Applicable	Once every 12 months
Ceramic Crown	Crowns	$0 Copay	Not Applicable	Replacement of crown requires existing restoration to be 5+ years old.
Removable Partial Denture	Dentures	$0 Copay	Not Applicable	Replacement of a partial denture requires the exiting denture to be 5+ years old
Extraction, Erupted Tooth with Bone Removal	Oral Surgery	$0 Copay	Not Applicable	Extractions solely for ortho purposes.
Orthodontia	Orthodontia	$800 - $2,100 Copay	Not Applicable	Treatment limited to a maximum of 24 months

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: $**0** Out-of-network: **Not Covered**	Total Cost of Care	In-network: **$0** Out-of-network: **Not Covered**	Total Cost of Care	In-network: **$0** Out-of-network: **Not Covered**
Deductible	In-network: Not Applicable Out-of-network: Not Applicable	Deductible	In-network: Not Applicable Out-of-network: Not Applicable	Deductible	In-network: Not Applicable Out-of-network: Not Applicable
Annual Maximum (Plan Will Pay)	In-network: Not Applicable Out-of-network: Not Applicable	Annual Maximum (Plan Will Pay)	In-network: Not Applicable Out-of-network: Not Applicable	Annual Maximum (Plan Will Pay)	In-network: Not Applicable Out-of-network: Not Applicable

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: Not Covered	Patient Cost (copayment or coinsurance)	In-network: $0 Out-of-network: Not Covered	Patient Cost (copayment or coinsurance)	In-network: $0 - $130 Out-of-network: Not Covered
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	**In-network: $0** **Out-of-network:** Not Covered	**In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network: $0** **Out-of-network:** Not Covered	**In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network: $0** **Out-of-network:** Not Covered
Summary of what is not covered or subject to a limitation:	1 series of 4 in any 6-month period 3 cleanings in a 12-month period	Summary of what is not covered or subject to a limitation:	No limitations or exclusions	Summary of what is not covered or subject to a limitation:	Replacement of crown requires existing restoration to be 5+ years old