Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: **LIBERTY Dental Plan of California, Inc. Small & Large Group Plans**

Name of Product: LIBERTY Dental Plan

Type of Product Line: DHMO

Plan Phone #: 888-703-6999/TTY: 877-855-8039

Effective Date: Beginning on or after 01/01/2023

Plan Website: LIBERTYDentalPlan.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 LIBERTYDentalPlan.com OR CALL 888-703-6999/TTY: 877-855-8039.

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	In-Network	Out-of-Network
Dental	None	Not Applicable
Orthodontia	None	Not Applicable

- **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 waitlist 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 include common limitations and exclusions only. For a full list, see the full disclosure document references 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	• No limitations or exclusions • Refer to the Evidence of Coverage for the full limitation and exclusion
Bitewing X-ray	Preventive & Diagnostic	$0	Not Covered	• No limitations or exclusions • Refer to the Evidence of Coverage for the full limitation and exclusion

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Cleaning	Preventive & Diagnostic	$8 - $45	Not Covered	• 1 every 6 months; additional cleanings covered with $45 copay. • Refer to the Evidence of Coverage for the full limitation and exclusion
Filling	Basic	$12 - $90	Not Covered	• Not payable within 12 months of initial filling if performed by the same provider or office. • Refer to the Evidence of Coverage for the full limitation and exclusion
Extraction, Erupted Tooth or Exposed Root	Basic	$15	Not Covered	• No limitations or exclusions • Refer to the Evidence of Coverage for the full limitation and exclusion
Root Canal	Basic	$100 - $220	Not Covered	• No limitations or exclusions • Refer to the Evidence of Coverage for the full limitation and exclusion
Scaling and Root Planing	Basic	$23 - $45	Not Covered	• 1 per site/quad every 24 months • No more than two (2) quadrants per appointment/per day are allowable. • Refer to the Evidence of Coverage for the full limitation and exclusion
Ceramic Crown	Major	$175	Not Covered	• 1 per tooth every 5-year period; covered for members age 16 and over • Refer to the Evidence of Coverage for the full limitation and exclusion
Removable Partial Denture	Major	$205 - $235	Not Covered	• 1 every 5-year period; if the appliance cannot be made functional through reline or repair • Refer to the Evidence of Coverage for the full limitation and exclusion
Extraction, Erupted Tooth with Bone Removal	Basic	$35	Not Covered	• No limitations or exclusions • Refer to the Evidence of Coverage for the full limitation and exclusion

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Orthodontia	Orthodontia	$1,300- $1,695	Not Covered	• Orthodontic coverage is limited to 24 months of treatment, followed by 24 months of retention office visits. Services provided after the 24th month of treatment and/or retention is the responsibility of the patient at a fee not to exceed $130 per month. • Refer to the Evidence of Coverage for the full limitation and exclusion

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-rays) 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**

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
Deductible	In-network: Not Applicable Out-of-network: Not Covered	Deductible	In-network: Not Applicable Out-of-network: Not Covered	Deductible	In-network: Not Applicable Out-of-network: Not Covered
Annual Maximum (Plan Will Pay)	In-network: Not Applicable Out-of-network: Not Covered	Annual Maximum (Plan Will Pay)	In-network: Not Applicable Out-of-network: Not Covered	Annual Maximum (Plan Will Pay)	In-network: Not Applicable Out-of-network: Not Covered
Patient Cost (copayment or coinsurance)	In-network: $8 Out-of-network: Not Covered	Patient Cost (copayment or coinsurance)	In-network: $65 Out-of-network: Not Covered	Patient Cost (copayment or coinsurance)	In-network: $175 Out-of-network: Not Covered
In this example, Dana Would pay (includes copays/coinsurance and deductible, if applicable):	In-network: $8 Out-of-network: $550	In this example, Sam would pay (Includes copays/coinsurance and deductible, if applicable):	In-network: $65 Out-of-network: $200	In this example, Sam would pay (Includes copays/coinsurance and deductible, if applicable):	In-network: $175 Out-of-network: $1,750
Summary of what is not covered or subject to a limitation:	1 every 6 months; additional cleanings covered with $45 copay. Intraoral, comprehensive series of radiographic images is limited to 1 series every 36 months	Summary of what is not covered or subject to a limitation:	Not payable within 12 months of initial filling if performed by the same provider or office.	Summary of what is not covered or subject to a limitation:	1 per tooth every 5-year period; covered for members age 16 and over