Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Insurer Name: Western Dental Plan

Plan Name: STCAEM

Policy Type: DHMO

Insurer Phone #: 1-800-992-3366

Effective Date: 01/01/2011

Insurer Website: https://www.westerndental.com/en-us/western-dental-group-insurance/for-members

Part I: General Information

This Matrix is intended to be used to help members compare covered benefits and what you will be your copay amount for covered services. This Matrix is a summary only and does not include the premium costs of this dental plan. Please review your Schedule of Covered Services and Evidence of Coverage (EOC) for the detailed description of coverage benefits, limitations, and exclusions. For more information about your coverage, visit the plan website at 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: Deductible

Deductible Type	In-Network	Out-of-Network
Dental	N/A	N/A
Orthodontia	N/A	N/A

- A deductible is the amount you are required to pay for covered dental services each policy year before the insurer begins to pay for the cost of covered dental treatment and before the insurance company pays out a claim.
- In-network services are dental care services provided by dentists or other licensed dental care providers who are contracted with the insurance company to provider dental services to members.
- Out-of-network services are dental care services provided by dentists or other licensed dental care providers who have not the insurance company to provider dental services to members.

Part IV: Waiting Periods

Waiting Periods: A waiting period is the amount of time that must pass before you are eligible to receive benefits for all or certain dental treatments.

Category	Waiting Period
Diagnostics	No Waiting Period
Preventative	No Waiting Period
Minor Restorative	No Waiting Period
Oral Surgery	No Waiting Period
Endodontics	No Waiting Period
Periodontics	No Waiting Period
Crowns	No Waiting Period
Dentures	No Waiting Period
Ortho	No Waiting Period

Part V: What you will pay

All copayments shown in the below 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	Diagnostics	$0 Copay	N/A	No limitations or exclusions
Bitewing X-ray	Diagnostics	$0 Copay	N/A	1 series of 4 in any 6-month period
Cleaning	Preventative	$0 Copay	N/A	Twice in 12-month period
Filling	Minor restorative	$0 - $70 Copay	N/A	No limitations or exclusions
Simple Extraction	Oral Surgery	$0 Copay	N/A	Extractions solely for ortho purposes
Root Canal	Endodontics	$20 - $60 Copay	N/A	No limitations or exclusions
Scaling and Root Planing	Periodontics	$0 Copay	N/A	Once every 12 months
Ceramic Crown	Crowns	$50 Copay	N/A	Replacement of crown requires existing restoration to be 5+ years old
Removable Partial	Dentures	$65 Copay	N/A	Replacement of a partial denture requires the exiting denture to be 5+ years old
Orthodontia	Ortho	$1,000 Copay	N/A	Treatment limited to a maximum of 24 months

WD PLAN
GROUP AND INDIVIDUAL

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: $40 Out-of-network: Not Covered	***Total Cost of Care***	In-network: $50 Out-of-network: Not Covered
Deductible	In-network: N/A Out-of-network: N/A	***Deductible***	In-network: N/A Out-of-network: N/A	***Deductible***	In-network: N/A Out-of-network: N/A
Annual Maximum (Plan Will Pay)	In-network: N/A Out-of-network: N/A	***Annual Maximum (Plan Will Pay)***	In-network: N/A Out-of-network: N/A	***Annual Maximum (Plan Will Pay)***	In-network: N/A Out-of-network: N/A
Patient Cost (copayment or coinsurance)	In-network: $0 Out-of-network: Not Covered	***Patient Cost (copayment or coinsurance)***	In-network: $40 Out-of-network: Not Covered	***Patient Cost (copayment or coinsurance)***	In-network: $50 Out-of-network: Not Covered
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	In-network: $0 Out-of-network: N/A	***In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):***	In-network: $40 Out-of-network: Not Covered	***In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):***	In-network: $50 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	***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