Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: Newport Dental Plan
Type of Product Line: DHMO
Effective Date: 01/01/2024

Name of Product: Sheet Metal Workers
Plan Phone #: 1-800-497-6453
Plan Website: www.newportdental.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.newportdental.com OR CALL 1-800-497-6453**.**

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	None	Not applicable
Lifetime or Annual 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. **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	No limitation
Bitewing X-ray	Preventive & Diagnostic	$0	Not Covered	Once every six months unless prescribed more frequently by treating provider.
Cleaning	Preventive & Diagnostic	$0	Not Covered	Once every six months unless prescribed more frequently by treating provider.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Filling	Basic	$0-50	Not applicable	No limitation
Extraction, Erupted Tooth or Exposed Root	Major	$0	Not applicable	Once per tooth, per lifetime. Asymptomatic teeth are excluded.
Root Canal	Major	$0	Not applicable	Once per tooth, per lifetime.
Scaling and Root Planing	Basic	$0	Not applicable	Once every six months per quadrant unless prescribed more frequently by treating provider.
Ceramic Crown	Major	$500	Not applicable	Crowns are not covered when a filling can adequately restore the dental health of the Member.
Removable Partial Denture	Major	$0	Not applicable	Replacement is allowed when the appliance cannot be made serviceable consistent with professional recognized standards of care.
Extraction, Erupted Tooth with Bone Removal	Major	$0	Not applicable	Once per tooth, per lifetime. Asymptomatic teeth are excluded.
Orthodontia	Orthodontia	$[1845-3800]	Not applicable	Treatment is limited to twenty-four (24) months. Orthodontic treatment following termination of coverage is excluded and the Member will be responsible for costs incurred following termination. Costs associated with optional/ elective materials are excluded from coverage and are the responsibility of the Member.

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: No deductible Out-of-network: Not covered	Deductible	In-network: No deductible Out-of-network: Not covered	Deductible	In-network: No deductible Out-of-network: Not covered
Annual Maximum (Plan Will Pay)	In-network: No Annual Maximum Out-of-network: Not applicable	Annual Maximum (Plan Will Pay)	In-network: No Annual Maximum Out-of-network: Not applicable	Annual Maximum (Plan Will Pay)	In-network: No Annual Maximum 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: $35 Out-of-network: Not covered	Patient Cost (copayment or coinsurance)	In-network: $500 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 applicable	**In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network: $35** **Out-of-network:** Not applicable	**In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network: $500** **Out-of-network:** Not applicable
Summary of what is not covered or subject to a limitation:	Full mouth-xrays are limited once/2 years; Cleanings once/6 months.	Summary of what is not covered or subject to a limitation:	Not applicable	Summary of what is not covered or subject to a limitation:	Crowns are not covered when a filling can adequately restore the tooth.