Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: DHMO - 805 SOC
Type of Product Line: DHMO
Effective Date: 01/01/2025-12/31/2025

Name of Product: 805
Plan Phone #: (888) 534-3466
Plan Website: www.socdhmo.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.socdhmo.com OR CALL (888) 534-3466.

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.

State of California, Health and Human Services Agency-Dept of Managed Health Care: DMHC 10-278, Effective 9/1/22

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	Preventive & Diagnostic	$0	Not Covered	Frequency limitation of 2 exams in any 12 month period. Please consult your Schedule of Benefits for a complete description of the limitations and exclusions for this product.

Bitewing X-ray	Preventive & Diagnostic	$0	Not Covered	Frequency limitation of two series of two films every 12 months; Frequency limitation of two series of four films every 12 months. Please consult your Schedule of Benefits for a complete description of the limitations and exclusions for this product.
Cleaning	Preventive & Diagnostic	$0	Not Covered	Frequency limitation of 2 in any 12 month period. Please consult your Schedule of Benefits for a complete description of the limitations and exclusions for this product.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Filling	Basic	$0	Not Covered	Limited to once every 12 months for primary teeth and once every 24 months for permanent teeth. Please consult your Schedule of Benefits for a complete description of the limitations and exclusions for this product.
Extraction, Erupted Tooth or Exposed Root	Basic	$0	Not Covered	Limited to once per lifetime per tooth. Please consult your Schedule of Benefits for a complete description of the limitations and exclusions for this product.
Root Canal	Basic	$20	Not Covered	Limited to once every 24 months. Please consult your Schedule of Benefits for a complete description of the limitations and exclusions for this product.
Scaling and Root Planing	Basic	$0	Not Covered	Limited to once every 12 months. Please consult your Schedule of Benefits for a complete description of the limitations and exclusions for this product.
Ceramic Crown	Major	$50	Not Covered	Limited to once every 60 months. Please consult your Schedule of Benefits for a complete description of the limitations and exclusions for this product.
Removable Partial Denture	Major	$65	Not Covered	Limited to once every 60 months. Please consult your Schedule of Benefits for a complete description of the limitations and exclusions for this product.
Extraction, Erupted Tooth with Bone Removal	Major	$0	Not Covered	Limited to once per lifetime per tooth. Please consult your Schedule of Benefits for a complete description of the limitations and exclusions for this product.

Orthodontia	Orthodontia	$$1,000 child $1,000 adult$1,000 child $1,000 adult	Not Covered	Coverage is limited to one course of comprehensive treatment per Member. Please consult your Schedule of Benefits for a complete description of the limitations and exclusions for this product.

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: None Out-of-network: Not Covered	Deductible	In-network: None Out-of-network: Not Covered	Deductible	In-network: None Out-of-network: Not Covered

Annual Maximum (Plan Will Pay)	In-network: None Out-of-network**:** Not Covered	Annual Maximum (Plan Will Pay)	In-network: None Out-of-network**:** Not Covered	Annual Maximum (Plan Will Pay)	In-network: None Out-of-network**:** Not Covered

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: $550	Patient Cost (copayment or coinsurance)	In-network: $45 Out-of-network: $200	Patient Cost (copayment or coinsurance)	In-network: $50 Out-of-network: $1,750
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	**In-network: $0** **Out-of-network: $550**	**In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network: $45** **Out-of-network: $200**	**In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network: $50** **Out-of-network: $1,750**
Summary of what is not covered or subject to a limitation:	Oral examinations are limited to 2 in a 12-month period.	Summary of what is not covered or subject to a limitation:	Limited to once every 12 months for primary teeth, and	Summary of what is not covered or subject to a limitation:	Frequency limitation of once every 60 months. Treatment

	Full mouth and panoramic x-rays are limited to once every 3 years, unless medically necessary. Cleanings are limited to 2 per 12-month period. Please consult your Schedule of Benefits for a complete description of the limitations and exclusions for this product.		once every 24 months for permanent teeth. Please consult your Schedule of Benefits for a complete description of the limitations and exclusions for this product.		plans in excess of 5-7 units will have an additional copayment of $125 per unit for 5-7 or more units. There may be an additional copayment for porcelain on molar crowns. In addition, if agreed upon, there can be an additional charge for upgraded materials such as high noble or noble metal, not included in the copayment. Please consult your Schedule of Benefits for a complete description of the limitations and exclusions for this product.