

Dental Plan Comparison Summary

PLAN YEAR 2027

	LIBERTY DENTAL INDEPENDENCE PPO		LIBERTY DENTAL COBALT PLUS DHMO	
Annual Maximum <i>(per person)</i>	\$2,500.00		None	N/A
Deductible <i>(per calendar year)</i>				
Individual	\$ 50.00		\$0.00	N/A
Family	\$150.00		\$0.00	N/A
COVERED SERVICES	IN-NETWORK PLAN PAYS	OUT-OF- NETWORK PLAN PAYS	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Preventive Services				
Prophylaxis	100% ^{1, 4}	70% ^{2, 4}	100% ³	No benefit
X-Rays	100% ¹	70% ²	100% ³	
Other Services - Restorative <i>(Amalgam, plastic, acrylic filling of cavities)</i>	90% ¹	70% ²	100% ³	No benefit
Endodontic <i>(Pulpal therapy and root canals)</i>	90% ¹	70% ²	100% ³	No benefit
Periodontics <i>(Treatment of gums and bones supporting teeth)</i>	90% ¹	70% ²	100% ³	No benefit
Prosthodontics <i>(Partial and complete dentures)</i>	90% ¹	70% ²	Patient pays: ³ \$55.00 - dentures \$25.00 - partial	No benefit
Crowns	90% ¹	70% ²	Patient pays: ³ \$45.00 to \$90.00	No benefit
Implants	90% ¹	70% ²	Consult Benefit Schedule	No benefit
Orthodontia <i>Adults and Children</i>	50% \$1,500 Lifetime Maximum	50% \$1,500 Lifetime Maximum	Contact LIBERTY Customer Service	No benefit

¹ Of negotiated/contracted fees. ² Of reasonable and customary charge. ³ Procedure must be listed in the schedule of benefits to be covered at 100%. Many other services are offered with a specified co-payment. ⁴ Deductible waived.

This document provides a summary of the plan's benefits only. For a complete description of benefits, limitations and exclusions, refer to the plan's documents.