Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Insurer Name:	**AARP Dental Insurance Plan**	**Plan Name:**	**Protect**
Policy Type:	**PPO**	**Insurer Phone #:**	866-261-4275
Effective Date:	**1/1/2025**	**Insurer Website:**	**deltadentalins.com/aarp**

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 insurer website at deltadentalins.com/aarp or call 866-261-4275.

This matrix is not a guarantee of expenses or payment.

Part II: DEDUCTIBLES

Deductible	All Providers
Dental	$90 per individual
Orthodontia	Not Applicable

- The deductible applies to all services.
- 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.
- **In-network services** are dental care services provided by dentists or other licensed dental care providers that contract with your insurer for alternative rates of payment for dental services.
- **Out-of-network services** are dental care services provided by dentists or other licensed dental care providers that have not contracted with your insurer for alternative rates of payment.

Part III: MAXIMUMS POLICY WILL PAY

Maximums	All Providers
Annual Maximum	$1000
Lifetime or Annual Maximum for Orthodontia	None

- **Annual maximum** is the maximum dollar amount your policy 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 policy 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 periods.**

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	All Providers	Benefit Limitations and Exclusions
Oral Exam	Preventive & Diagnostic	20% Deductible does not apply	• 2 per calendar year • Refer to the Certificate of Coverage document for the full limitation and exclusion
Bitewing X-ray	Preventive & Diagnostic	20% Deductible does not apply	• 2 per calendar year, to age 18 • 1 per calendar year, age 18+ • Refer to the Certificate of Coverage document for the full limitation and exclusion.
Cleaning	Preventive & Diagnostic	20% Deductible does not apply	• 2 per calendar year • Refer to the Certificate of Coverage document for the full limitation and exclusion
Filling	Basic	20%	• Refer to the Certificate of Coverage document for the full limitation and exclusion
Extraction, Erupted Tooth or Exposed Root	Major	50%	• Refer to the Certificate of Coverage document for the full limitation and exclusion
Root Canal	Major	50%	• Refer to the Certificate of Coverage document for the full limitation and exclusion.
Scaling and Root Planing	Major	50%	• Refer to the Certificate of Coverage document for the full limitation and exclusion.
Ceramic Crown	Major	50%	• Refer to the Certificate of Coverage document for the full limitation and exclusion.
Removable Partial Denture	Major	50%	• Refer to the Certificate of Coverage document for the full limitation and exclusion.
Extraction, Erupted Tooth with Bone Removal	Major	50%	• Refer to the Certificate of Coverage document for the full limitation and exclusion.
Orthodontia	Orthodontia	Not covered	

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.

	Example 1	Example 2	Example 3
Activity	**Dana Has a Dental Appointment with a New Dentist**	**Sam Needs a Tooth Filled**	**Maria Needs a Crown**
Procedure	New patient exam, x-rays (FMX) and cleaning	Resin-based composite – one surface, posterior	Crown – porcelain/ceramic substrate
Total Cost	In-network: $400 Out-of-network: $550	In-network: $150 Out-of-network: $200	In-network: $1,300 Out-of-network: $1,750
Deductible	In-network: $0 Out-of-network: $0	In-network: $90 Out-of-network: $90	In-network: $90 Out-of-network: $90
Annual Maximum (Plan Will Pay)	In-network: $1,000 Out-of-network: $1,000	In-network: $1,000 Out-of-network: $1,000	In-network: $1,000 Out-of-network: $1,000
Patient Cost (copayment or coinsurance)	In-network: 20% Out-of-network: 20%	In-network: 20% Out-of-network: 20%	In-network: 50% Out-of-network: 50%

Part VI: COVERAGE EXAMPLES, cont.

Patient would pay (includes copays/coinsurance and deductible, if applicable):	In-network: $80 Out-of-network: $110	In-network: $102 Out-of-network: $112	In-network: $695 Out-of-network: $920
Summary of what is not covered or subject to a limitation	Oral examinations allowed three times per calendar year. FMX limited to once per 60 months. Cleanings are allowed three times per year		