Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: Delta Dental PPO™ Premium Plan
Type of Product Line: DPPO
Effective Date: Beginning on or after 01/01/26

Name of Product: Delta Dental PPO
Plan Phone #: 888-282-8784
Plan Website: deltadentalins.com/individuals

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 THEPLAN WEBSITE deltadentalins.com/individuals OR CALL 888-282-8784

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	In-Network	Out-of-Network
Dental	$50 per individual $150 per family	$50 per individual $150 per family
Orthodontia	$50 per individual	$50 per individual

- **The deductible applies to all services except Preventive & Diagnostic services.**
- 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	$2,000 per individual	$2,000 per individual
Lifetime or Annual Maximum for Orthodontia	$1,500 per individual	$1,500 per individual

- **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 a 6-month waiting period for Basic Services, Major Services, and Orthodontic Services. This waiting period is waived with proof of prior coverage.**

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 Limitation and Exclusions
Oral Exam	Preventive & Diagnostic	0%	0%	• 2 per calendar year; 1 per lifetime per dentist/dental office • Refer to the Disclosure Form for the full limitations and exclusion
Bitewing X-ray	Preventive & Diagnostic	0%	0%	• 2 per calendar year; to age 18; 1 per calendar, age 18+ • Refer to the Disclosure Form for the full limitations and exclusion
Cleaning	Preventive & Diagnostic	0%	0%	• 2 per calendar year • Refer to the Disclosure Form for the full limitations and exclusion
Common Dental Procedures	**Category**	**In-Network**	**Out-of-Network**	**Benefit Limitations and Exclusions**
Filling	Basic	20%	20%	• Not billable to Delta or Enrollee within 24-months to same dentist/dental office that performed original restoration on same surface • Basic services include a 6-month waiting period; waived with proof of prior coverage • Refer to the Disclosure Form for the full limitation and exclusion
Extraction, Erupted Tooth or Exposed Root	Major	50%	50%	• 1 per lifetime • Major services include a 6-month waiting period; waived with proof of prior coverage • Refer to the Disclosure Form for the full limitation and exclusion
Root Canal	Major	50%	50%	• 1 per lifetime • Major services include a 6-month waiting period; waived with proof of prior coverage • Refer to the Disclosure Form for the full limitation and exclusion

Scaling and Root Planing	Major	50%	50%	• 1 per 24 months • Major services include a 6-month waiting period; waived with proof of prior coverage • Refer to the Disclosure Form for the full limitation and exclusion
Ceramic Crown	Major	50%	50%	• 1 per 60 months, age 12 and over • Major services include a 6-month waiting period; waived with proof of prior coverage • Refer to the Disclosure Form for the full limitation and exclusion
Removable Partial Denture	Major	50%	50%	• 1 per 60 months; age 16 and over • Major services include a 6-month waiting period; waived with proof of prior coverage • Refer to the Disclosure Form for the full limitation and exclusion
Extraction, Erupted Tooth with Bone Removal	Major	50%	50%	• 1 per lifetime • Major services include a 6-month waiting period; waived with proof of prior coverage • Refer to the Disclosure Form for the full limitation and exclusion
Orthodontia	Orthodontia	50%	50%	• Orthodontic services include a 6-month waiting period; waived with proof of prior coverage • Refer to the Disclosure Form for the full limitation and exclusion

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: $50 per individual $150 per family Out-of-network: $50 per individual $150 per family	Deductible	In-network: $50 per individual $150 per family Out-of-network: $50 per individual $150 per family	Deductible	In-network: $50 per individual $150 per family Out-of-network: $50 per individual $150 per family
Annual Maximum (Plan Will Pay)	In-network: $2,000 per individual Out-of-network: $2,000 per individual	Annual Maximum (Plan Will Pay)	In-network: $2,000 per individual Out-of-network: $2,000 per individual	Annual Maximum (Plan Will Pay)	In-network: $2,000 per individual Out-of-network: $2,000 per individual

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: 0%	Patient Cost (copayment or coinsurance)	In-network: 20% Out-of-network: 20%	Patient Cost (copayment or coinsurance)	In-network: 50% Out-of-network: 50%
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	**In-network:** $0 **Out-of-network:** $0	**In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** $70 **Out-of-network:** $80	**In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** $675 **Out-of-network:** $900
Summary of what is not covered or subject to a limitation:	Oral examinations: allowed twice per calendar year. Cleanings: (regular and periodontal) are subject to a 30-day wait following periodontal scaling and root planing if performed by the same Provider's office. full-mouth x-ray: limited to once per 60 months.	Summary of what is not covered or subject to a limitation:	Replacement of a resin-based composite restoration is covered within 24 months of treatment if the service is provided by the same Provider. Replacement restorations within 24 months are included in the fee for the original restoration.	Summary of what is not covered or subject to a limitation:	Limited to 1 per 60 months, age 12+.