

Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: SMALL BUSINESS DENTAL TRUST

Type of Product Line: DPPO

Effective Date: Beginning on or after 07/01/21.

Name of Product: Delta Dental PPO

Plan Phone #: 888-335-8227

Plan Website: deltadentalins.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 DELTADENTALINS.COM OR CALL 888-335-8227.

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

| Deductible | In-Network | Out-of-Network |
|-------------------|---|-----------------------|
| Dental | PPO - None Premier - Individual = \$50 | Individual = \$50 |
| Orthodontia | Not Covered | Not Covered |

- **The deductible applies to all services except Diagnostic & Preventive services for Premier dentists, and for Out-of-Network dentists.**
- 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 | PPO - \$1000 Premier - \$1000 | \$1000 |
| Lifetime or Annual Maximum for Orthodontia | Not Covered | Not Covered |

- **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 does not contain 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 | In-Network | Out-of-Network | Benefit Limitations and Exclusions |
|--------------------------|---------------------------|---------------------------|----------------|--|
| <i>Oral Exam</i> | Preventive and Diagnostic | PPO - 0% Premier - 20% | 20% | <ul style="list-style-type: none"> • Two per calendar year. • Refer to the Evidence of Coverage for full limitations and exclusions. |
| <i>Bitewing X-ray</i> | Preventive and Diagnostic | PPO - 0% Premier - 20% | 20% | <ul style="list-style-type: none"> • Two per calendar year. • Refer to the Evidence of Coverage for full limitations and exclusions. |

| Common Dental Procedures | Category | In-Network | Out-of-Network | Benefit Limitations and Exclusions |
|--|---------------------------|----------------------------|-----------------------|--|
| <i>Cleaning</i> | Preventive and Diagnostic | PPO - 0% Premier - 20% | 20% | <ul style="list-style-type: none"> • Two per calendar year. • Refer to the Evidence of Coverage for full limitations and exclusions. |
| <i>Filling</i> | Basic | PPO - 20% Premier - 50% | 50% | <ul style="list-style-type: none"> • Replacement of an amalgam or composite fillings are not covered within 24 months. • Refer to the Evidence of Coverage for full limitations and exclusions. |
| <i>Extraction, Erupted Tooth or Exposed Root</i> | Basic | PPO - 20% Premier - 50% | 50% | <ul style="list-style-type: none"> • Once per lifetime. • Refer to the Evidence of Coverage for full limitations and exclusions. |
| <i>Root Canal</i> | Major | PPO - 20% Premier - 50% | 50% | <ul style="list-style-type: none"> • Once per 60 months. • Refer to the Evidence of Coverage for full limitations and exclusions. |
| <i>Scaling and Root Planing</i> | Basic | PPO - 20% Premier - 50% | 50% | <ul style="list-style-type: none"> • Scaling and root planing in the same quadrant are limited to once every 24 months. 15 years and older. • Refer to the Evidence of Coverage for full limitations and exclusions. |
| <i>Ceramic Crown</i> | Major | PPO - 50% Premier - 50% | 50% | <ul style="list-style-type: none"> • One in 60 months. • Refer to the Evidence of Coverage for full limitations and exclusions. |
| <i>Removable Partial Denture</i> | Major | PPO - 50% Premier - 50% | 50% | <ul style="list-style-type: none"> • One in 60 months. • Refer to the Evidence of Coverage for full limitations and exclusions. |
| <i>Extraction, Erupted Tooth with Bone Removal</i> | Major | PPO - 20% Premier - 50% | 50% | <ul style="list-style-type: none"> • One in a lifetime. • Refer to the Evidence of Coverage for full limitations and exclusions. |

| Common Dental Procedures | Category | In-Network | Out-of-Network | Benefit Limitations and Exclusions |
|---------------------------------|-----------------|-------------------|-----------------------|---|
| <i>Orthodontia</i> | Orthodontia | Not Covered | Not Covered | <ul style="list-style-type: none">• 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.

| 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: PPO - \$0 Premier - \$0 Out-of-network: \$0 | Deductible | In-network: PPO - \$0 Premier - \$50 Out-of-network: \$50 | Deductible | In-network: PPO - \$0 Premier - \$50 Out-of-network: \$50 |
| Annual Maximum (Plan Will Pay) | In-network: PPO - \$1000 Premier - \$1000 Out-of-network: \$1000 | Annual Maximum (Plan Will Pay) | In-network: PPO - \$1000 Premier - \$1000 Out-of-network: \$1000 | Annual Maximum (Plan Will Pay) | In-network: PPO - \$1000 Premier - \$1000 Out-of-network: \$1000 |

| 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: PPO - 0% Premier - 20% Out-of-network: 20% | Patient Cost (copayment or coinsurance) | In-network: PPO - 20% Premier - 50% Out-of-network: 50% | Patient Cost (copayment or coinsurance) | In-network: PPO - 50% Premier - 50% Out-of-network: 50% |
| In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable): | In-network: PPO - \$0 Premier - \$80 Out-of-network: \$110 | In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable): | In-network: PPO - \$30 Premier - \$100 Out-of-network: \$125 | In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable): | In-network: PPO - \$650 Premier - \$675 Out-of-network: \$900 |
| Summary of what is not covered or subject to a limitation: | Oral exams are limited to two per calendar year. Cleanings are limited to two per calendar year. Full mouth x-rays are limited to once every 60 months. | Summary of what is not covered or subject to a limitation: | Replacement of an amalgam or composite fillings are not covered within 24 months of treatment. | Summary of what is not covered or subject to a limitation: | Crowns are limited to one in 60 months. |