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 07/01/23.

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	PPO - None Premier - None	None

- **The deductible applies to all services except Diagnostic, Preventive & Orthodontic 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.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Oral Exam	Preventive and Diagnostic	PPO - 0% Premier - 0%	0%	• Two per calendar year. • Refer to the Evidence of Coverage for full limitations and exclusions.
Bitewing X-ray	Preventive and Diagnostic	PPO - 0% Premier - 0%	0%	• Two per calendar year. • Refer to the Evidence of Coverage for full limitations and exclusions.
Cleaning	Preventive and Diagnostic	PPO - 0% Premier - 0%	0%	• Two per calendar year. • Refer to the Evidence of Coverage for full limitations and exclusions.
Filling	Basic	PPO - 10% Premier - 10%	10%	• Replacement of an amalgam or composite fillings are not covered within 24 months of treatment. • Refer to the Evidence of Coverage for full limitations and exclusions.
Extraction, Erupted Tooth or Exposed Root	Basic	PPO - 10% Premier - 10%	10%	• Once per lifetime. • Refer to the Evidence of Coverage for full limitations and exclusions.
Root Canal	Major	PPO - 10% Premier - 10%	10%	• Once per lifetime. • Refer to the Evidence of Coverage for full limitations and exclusions.
Scaling and Root Planing	Basic	PPO - 10% Premier - 10%	10%	• 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.
Ceramic Crown	Major	PPO - 40% Premier - 40%	40%	• One in 60 months. • Refer to the Evidence of Coverage for full limitations and exclusions.
Removable Partial Denture	Major	PPO - 40% Premier - 40%	40%	• One in 60 months. • Refer to the Evidence of Coverage for full limitations and exclusions.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Extraction, Erupted Tooth with Bone Removal	Major	PPO - 10% Premier - 10%	10%	• One in a lifetime. • Refer to the Evidence of Coverage for full limitations and exclusions.
Orthodontia	Orthodontia	PPO - 50% Premier - 50%	50%	• Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered. • Refer to the Evidence of Coverage for full limitations and exclusions.

Part III: MAXIMUMS PLAN WILL PAY

Maximums	In-Network	Out-of-Network
Annual Maximum	PPO - $2500 Premier - $2000	$2000
Lifetime or Annual Maximum for Orthodontia	PPO - $2000 Lifetime Premier - $2000 Lifetime	$2000 Lifetime

- **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.

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 - **$2500** Premier - **$2000** Out-of-network: **$2000**	Annual Maximum (Plan Will Pay)	In-network: PPO - **$2500** Premier - **$2000** Out-of-network: **$2000**	Annual Maximum (Plan Will Pay)	In-network: PPO - **$2500** Premier - **$2000** Out-of-network: **$2000**

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 - **0%** Out-of-network: **0%**	Patient Cost (copayment or coinsurance)	In-network: PPO - **10%** Premier - **10%** Out-of-network: **10%**	Patient Cost (copayment or coinsurance)	In-network: PPO - **40%** Premier - **40%** Out-of-network: **40%**
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	**In-network: PPO - $0 Premier - $0 Out-of-network: $0**	**In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network: PPO - $15 Premier - $60 Out-of-network: $65**	**In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network: PPO - $520 Premier - $550 Out-of-network: $730**
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.