Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: Children's HealthCare of California
Type of Product Line: DPPO
Effective Date: Beginning on or after 01/01/23.

Name of Product: Delta Dental PPO plus Premier
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 EVDIDENCE 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 - Individual = $50 Family = $150 Premier - Individual = $50 Family = $150	Individual = $50 Family = $150

- **The deductible applies to all services except Diagnostic, Preventive & Orthodontic services for all 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 yourplan 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 - $1500 Premier - $1500	$1500
Lifetime or Annual Maximum for Orthodontia	PPO - $1500 Lifetime Premier - $1500 Lifetime	$1500 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.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Oral Exam	Diagnostic and Preventive	PPO - 0% Premier - 0%	0%	• Twice in a calendar year • Refer to Attachment B of your Evidence of Coverage for full limitations and exclusions
Bitewing X-ray	Diagnostic and Preventive	PPO - 0% Premier - 0%	0%	• Limited to two (2) times in a calendar year for individuals under age 18 and one (1) time in a calendar year for individuals age 18 and over.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
				• Bitewing X-rays are limited to two images for enrollees under age 10. • Bitewings are disallowed within 12 months of a full mouth X-rays unless warranted by special circumstances. • Refer to Attachment B of your Evidence of Coverage for full limitations and exclusions.
Cleaning	Diagnostic and Preventive	PPO - 0% Premier - 0%	0%	• Limited to two (2) times in a calendar year. • Full mouth debridement and other periodontal cleanings are covered under a different benefit category, but will count toward the cleaning frequency. • One (1) additional cleaning will be allowed in a calendar year for individuals who are pregnant. Written confirmation of pregnancy must be provided when the claim is submitted. • Refer to Attachment B of your Evidence of Coverage for full limitations and exclusions.
Filling	Basic	PPO - 20% Premier - 20%	20%	• Replacement of an amalgam or composite fillings are not covered within 24 months of treatment if the service is provided by the same dentist. • Composite fillings on back teeth are considered an optional service. An alternate benefit for an amalgam filling will be allowed. You will be responsible for the cost difference between the composite filling and the amalgam filling. • Fillings to restore tooth structure lost from wear, erosion, or abrasion are not covered. • Refer to Attachment B of your Evidence of Coverage for full limitations and exclusions.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Extraction, Erupted Tooth or Exposed Root	Basic	PPO - 20% Premier - 20%	20%	• Covered once in a lifetime. • Refer to Attachment B of your Evidence of Coverage for full limitations and Exclusions
Root Canal	Basic	PPO - 20% Premier - 20%	20%	• Root canals having a questionable prognosis based on a dental consultant's professional review of submitted documentation will not be covered. • Refer to Attachment B of your Evidence of Coverage for full limitations and exclusions.
Scaling and Root Planing	Basic	PPO - 20% Premier - 20%	20%	• Scaling and root planing in the same quadrant are limited to once every 24 months. • Refer to Attachment B of your Evidence of Coverage for full limitations and exclusions.
Ceramic Crown	Major	PPO - 50% Premier - 50%	50%	• Limited to individuals age 12 and older. • Limited to once in a 60-month period. • If a crown is placed within six (6) months of a filling, the benefit for the crown will be reduced by the benefit paid for the filling. • Refer to Attachment B of your Evidence of Coverage for full limitations and exclusions.
Removable Partial Denture	Major	PPO - 50% Premier - 50%	50%	• Limited to once every 60 months. • Refer to Attachment B of your Evidence of Coverage for full limitations and Exclusions
Extraction, Erupted Tooth with Bone Removal	Basic	PPO - 20% Premier - 20%	20%	• Covered once in a lifetime • Refer to Attachment B of your Evidence of Coverage for full limitations and exclusions.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Orthodontia	Orthodontia	PPO - 50% Premier - 50%	50%	• Benefits for orthodontic services will be provided in periodic payments based on the individual's continuing eligibility. • Benefits for orthodontic services are limited to individuals under the age of 25. • Self-administered orthodontics are not covered. Orthodontic treatment must be provided by a licensed dentist. • Refer to Attachment B of your Evidence of Coverage for full limitations and exclusions.

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 - **$50** Premier - **$50** Out-of-network: **$50**	Deductible	In-network: PPO - **$50** Premier - **$50** Out-of-network: **$50**
Annual Maximum (Plan Will Pay)	In-network: PPO - **$1500** Premier - **$1500** Out-of-network: **$1500**	Annual Maximum (Plan Will Pay)	In-network: PPO - **$1500** Premier - **$1500** Out-of-network: **$1500**	Annual Maximum (Plan Will Pay)	In-network: PPO - **$1500** Premier - **$1500** Out-of-network: **$1500**

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 - **20%** Premier - **20%** Out-of-network: **20%**	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 - $0 Out-of-network: $0**	**In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network: PPO - $70 Premier - $70 Out-of-network: $80**	**In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network: PPO - $675 Premier - $675 Out-of-network: $1,000**
Summary of what is not covered or subject to a limitation:	• If Dana had already received two (2) exams in the calendar year by other dentists, this exam would not be covered. • If Dana had already received two (2) cleanings in the calendar year this cleaning would not be covered, unless Dana was pregnant and written	Summary of what is not covered or subject to a limitation:	• Composite fillings on back teeth are considered an optional service. An alternate benefit for an amalgam filling will be allowed. You will be responsible for the cost difference between the composite filling and the amalgam filling. • Replacement of an amalgam or	Summary of what is not covered or subject to a limitation:	• Limited to individuals age 12 and older. • Limited to once in a 60-month period. If a crown is placed within six (6) months of a filling, the benefit for the crown will be reduced by the benefit paid for the filling.

	confirmation of the pregnancy is submitted with the claim. • If Dana had received an FMX within the last 60 months the FMX would not be covered.		composite fillings are not covered within 24 months of treatment if the service is provided by the same dentist. • Fillings to restore tooth structure lost from wear, erosion, or abrasion are not covered.		