Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: CAD91- San Bernardino County
Type of Product Line: DHMO
Effective Date: Beginning on or after 1/1/2026.

Name of Product: DeltaCare® USA
Plan Phone #: 800-422-4234
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 800-422-4234.

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	In-Network	Out-of-Network
Dental	None	Not Applicable

- **There is no deductible.**
- 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	None	Not applicable
Lifetime Maximum for Orthodontia	None	Not applicable

- **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 no waiting period.**

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	Preventative & Diagnostic	$0	Not covered	- No limitations or exclusions.
Bitewing X-ray	Preventative & Diagnostic	$0	Not covered	- No limitations or exclusions.

Cleaning	Preventative & Diagnostic	$0-$40	Not covered	- 2 per 6 month period. - Additional prophylaxis cleaning - adult - in addition to the 2 D1110, D1120 or D4346 per calendar year.
Filling	Basic	$0	Not covered	- No limitations or exclusions
Extraction, Erupted Tooth or Exposed Root	Basic	$2	Not covered	- No limitations or exclusions
Root Canal	Basic	$135	Not covered	- Limited to permanent teeth only.
Scaling and Root Planing	Basic	$25	Not covered	- Limited to 4 quadrants during any 24 consecutive months.
Ceramic Crown	Major	$210	Not covered	- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.
Removable Partial Denture	Major	$120	Not covered	- Replacement of a partial denture requires the existing denture to be 5+ years old.
Extraction,Erupted Tooth with Bone Removal	Basic	$13	Not covered	- No limitations or exclusions.
Orthodontia	Orthodontia	$1,000	Not covered	- Comprehensive orthodontic treatment of adolescent dentition - adolescent to age 19

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: None Out-of-network: Not covered	Deductible	In-network: None Out-of-network: Not covered	Deductible	In-network: None Out-of-network: Not covered
Annual Maximum (Plan Will Pay)	In-network: None Out-of-network: Not covered	Annual Maximum (Plan Will Pay)	In-network: None Out-of-network: Not covered	Annual Maximum (Plan Will Pay)	In-network: None Out-of-network: Not covered

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: Not covered	Patient Cost (copayment or coinsurance)	In-network: $35 Out-of-network: Not covered	Patient Cost (copayment or coinsurance)	In-network: $210 Out-of-network: Not covered
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	**In-network:** $0 **Out-of-network:** $550	**In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network: $35** **Out-of-network:** Not Covered	**In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network: $210** **Out-of-network:** Not Covered
Summary of what is not covered or subject to a limitation:	**Exam:** - No limitations or exclusions. **X-rays (FMX):** - Limited to either 1 comprehensive intraoral radiographic series or 1 panoramic radiographic image every 24 months. **Cleaning:** Cleaning is limited to 4 per 12 month period.	Summary of what is not covered or subject to a limitation:	- No limitations or exclusions	Summary of what is not covered or subject to a limitation:	No limitations or exclusions